Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Mo. . Decedent's Name (First, Middle, Last) 2. Date of Death 2005^{Year} Day July Month **Physician** Mabel Virginia Lampel 24. 10:20A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 1 F Yrs. Director 215–26–8622 March16,1928 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f show any july or paher traumatic event, the Madical Examinar must be notified at once. Prince George's Beltsville Maryland Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 3121 Christine Drive 20705 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. Yes ZNNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3√ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rory Potter Mary Haines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3121 Christine Drive Beltsville, Maryland 20705 Judy Brown -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Church of the Bretheran 7/29/2005 Brownsville, Maryland * 4 ☐Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licenses None Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Exacerbation of Chronic Obstructive Pulmonary Disease 4 days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician requires that the death certificate be Physiclan/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? o Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown n signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular Accident; Urinary Tract Infection 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Tes 2**X** No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D24721 July 25, 2005 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadiq, M.D. 14333 Laurel Bowie Rd., #208 Laurel, Maryland 20708 32 Registrar's Signature 31. Date filed (Month, Day, Year) JUL 2 6 2005 State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 00 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 9:15a M July 20 2005 Sheng Yen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ital 01ney

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Montgomery Montgomery General Hospital 8. Date of Birth (Month, Day, Year) 6. Sex M 2□F Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 80 Yrs. Director China 524 60 3064 Usual Residence of Deced with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo Montgomery Silver Spring Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 USA 15100 Interlachen Drive #201 Funerai 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 色 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: Asian þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **US** Government Chemist other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill ment of Health and Mental Htant: If Item 27 is marked oth jury or other traumatic even Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 718 Harrisburg Drive Davidsonville, Maryland 21035 May Lee Tate / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State '4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 7/30/05 Silver Spring, Maryland permit.
Departr
imports
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Archythmic Cardine Amyt **Physician** /Medical Due to (or as a consequent of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Leader of Ind.) that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) by the a 9 Unknown 9 Unknown been signed beta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Chrone Renal Facture Completed Nephrechony 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificate 1 Yes 2 No 1 Tes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐ No 2 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral (29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 050410 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mestgemeny General Hospital, chey, Mi) MD 31. Date filed (Month, Day, Year) State JUL 2 6 2005 Registrar

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Funeral Director		571-68-3321	Sex 7. A	ge (In yrs. 56	last birthday) Yrs.	If Under 1 Yes		Min. 8. Date of (Month, Sept.	Birth Day, Yea 28 1		Birthplace <i>(State or Foreig</i> <i>Country)</i> Nebraska
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h with the	Funeral Director	10e. Street and Number 18816 Bent Will	ow Circle,	#411		10f. Zip Code	20874	1		Citizen of What	,
be filed within 72 hours after death with the Maryland tall Hygiene. Id other than "natural", or Items 23a or 28a-f ehow event. The Medical Examinar malter civilia.	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Amed Forces 1 Yes 2 If Yes, Give Year or Dates:	? 'No		Was Decedent of Yes, specify Co		? (Specify Yes or Juerto Rican, etc.)	No-		American Indian, White, etc. White
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permit. Pag Department Importent: I any injury o		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Full eral Section lice	ensee	OH	22		ress of Facility H. Barb	er Funera	al Ho	ome	
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death certific	rnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3	Ectopic pregnar Other (specify)	осу			23d. Date of Month	delivery Day Year
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To the Hospitel o within 24 hours ef To the Funerel D completely filled it	egical cel	29a. Certifier (Check only one)	hysicien: To the best miner: On the basis of	of my kno	wledge, death	n occurred at the	time, date and p	lace, and due to the	ne cause(s) and manner	r as stated. due to the cause(s)
	_	29b. Signature and title of certifier	and manner si	1			nse number			ate signed (Mi	onth, Day, Year)
D		30. Name and address of person who DAVID A. CHARLE				Print)	59843 ROAD, #	410, ROCI	,		20850
State Registra	1	31. Date filed (Month, Day, Year) JUL 2 6 2	22 Pagiet	rar's Signa				•			

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o the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death	think as foods are desure. o the Funeral Director: After this certificate has been signed by the attending physician and orpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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nformant's Name/Relationship ginia L. Hicks ethod of Disposition	(Type, Print)	19b. Mailing Address (Street and Number o		JIII TIIO	
ginia L. Hicks			e Dural Davida Number 1		
ethod of Disposition	s/daugner	/833 ASDIEV GIAD RO			
			1.00	ile, VA ZZU	03
	l com	e of Disposition (Name of letery, crematory or other place)	Date 20	c. Location - City or Town	ı, State
_Aburiai 2 □ Cremation 3 L □Donation 5 □ Other (Speci		an Chapel Cem. Ju	ıly 21,2005	Sykesville	, MD
nature of Funeral Service Lice	· · · · · · · · · · · · · · · · · · ·	22. Name and Address of Facility	ALC: N		
Link of V	Vell 1	Fellows, Helfenb	ein & Newna	Funeral Hor	me, PA
eart1. Enter the disease or un	molis floors that caused the death. I	Do not enter the mode of dying, such as car			pproximate
hock, or heart failure. List only	y one cause on each line.	. 0.		In	terval Betweer
diate Cause (Final e or condition ng in death)	- Congetter	of Hear Tolling)		
(()	Due to (or as a consequen	ice of):			
ntially list conditions, leading to immediate	b				
Enter Underlying	Due to (or as a consequen	ice of):			
(Disease or injury tiated events	c				
ng in death) Last	Due to (or as a consequen	ice of):			
	d				
MALE: /as decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery	
the past 12 months?	1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death			Month Da	ay Year
Unknown	9□Unknown				
Other significant conditions	contributing to death but not resultir	ng in the underlying cause given in Part I.	23e. Did toba	cco use contribute to the c	cause of death'
			1 ☐ Yes	2☐No 3☐Probabl	ly 4 🗍 Unkno
			24a. Was an autopsy		y findings availa iletion of cause
			performe		100
		26. Place of	Death (Check only one))	
as case referred to medical		VOutpatient 3☐ DOA Other: 4☐ Nursin	ng Home 5 Residen	ce 6 ∏Other (Specify)	
as case referred to medical aminer?	Hospital: 1 Inpatient 2 ER	Bb. Time of 28c. Injury at	28d. Describe how		
aminer?	28a. Date of Injury 28	Injury Work?			
aminer? Yes 2D No nner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)			et and Number or Rural R	loute Number
miner? Yes 2 No nnerof Death Natural 5 Pending Accident investigatic Suicide 6 Could not l	28a. Date of Injury (Month, Day Year)	M 1 Yes 2 No	28f Location (Stre		odio mambon,
miner? Yes 2 No nnerof Death Natural 5 Pending Accident investigatic Suicide 6 Could not l	28a. Date of Injury (Month, Day Year)	M 1 Yes 2 No			
aminer? Yes 2 No nne of Death Natural 5 Pending Accident investigatic Suicide 6 Could not to determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify)	M 1 □ Yes 2 □ No e, farm, street, factory, office	City or Town,		ad
miner? Yes 2 No No Natural 5 Pending Accident investigatic Suicide 6 Could not Homicide determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) 28b. Physicien: To the best of my knowle	M 1 ☐ Yes 2 ☐ No e, farm, street, factory, office edge, death occurred at the time, date and p	City or Town,	se(s) and manner as state	e cause(s)
aminer? Yes 2 No nney of Death Matural 5 Pending investigation Suicide 6 Could not I determined Pertifier Check only One) Aminer? Certifying P 2 Medical Exa	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) 28b. Physicien: To the best of my knowle	M 1 □ Yes 2 □ No e, farm, street, factory, office	City or Town,	e and place, and due to th	ne cause(s)
miner? Yes 2 No nne of Death Matural 5 Pending Accident investigation Suicide 6 Could not I determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) Physicien: To the best of my knowle aminer: On the basis of examination	M 1 Tyes 2 No e, farm, street, factory, office edge, death occurred at the time, date and p n and/or investigation, in my opinion, death of 29c. License number	City or Town, place, and due to the cau occurred at the time, date	ise(s) and manner as state e and place, and due to th d. Date signed (Month, Day	ne cause(s)
aminer? Yes 2 No nner of Death Natural Accident Suicide Homicide Sertifier Certifying P Certifying P Check only Signature and till of certifier	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) Physicien: To the best of my knowle aminer: On the basis of examination and manner stated.	M 1 Yes 2 No e, farm, street, factory, office edge, death occurred at the time, date and p n and/or investigation, in my opinion, death of	City or Town, place, and due to the cau occurred at the time, date	e and place, and due to th	ne cause(s)
aminer? Yes 2 No nner of Death Natural Accident Suicide Homicide Sertifier Certifying P Certifying P Check only Signature and till of certifier	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) Physicien: To the best of my knowle aminer: On the basis of examination	M 1 Yes 2 No e, farm, street, factory, office edge, death occurred at the time, date and p n and/or investigation, in my opinion, death of	City or Town, place, and due to the cau occurred at the time, date	e and place, and due to the d. Date signed (Month, Date)	ne cause(s)
n	Yes 2 No ner of Death	Natural S Creming	Activity 6 Could not be	Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory office 28f. Location (Street)	Suicide Suicide Getermined 6 Could not be determined 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Richard City or Town, State)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of Ma	aryıan	•	tificate		neaith and r Death	_	Reg. No. 2 ())5 2	6006
	Physician		1. Decedent's Name (First, Middle, Last)							2. Dete of De Month	eth Dey	Year 3.1	Time of Death
Y	/Medica			LAYCOCK						JULY			:15pm
1	Examine	r	4e Fecility Neme (If not institution, give						4b. City, Town, or L				
			15B-1 SPA CREEK I 5. Sociel Security Number 6. Sec		e (In vrs	last birthdey)	if Under		ANNAPOLIS If Under 24 Hrs.			ARUNDEL 9 Birtholece /	
	Funeral Director			M 2□F		59 Yrs.		Deys	Hours Min.	8. Date of Bir (Month, De MAY 31	, 1946	WASHING	(State or Foreign FON D.C.
	ehow		10a. Stete 10b. County			y, Town or Lo	cation	П					nside City Limits
	Ne M		MARYLAND ANNE ARUI	NDEL	ANN	APOLIS	104 7:-4	Cada			10g. Citizen of V		
	with	5	10e. Street end Number	NIDTIG			10f. Zip (
	eath		15B-1 SPA CREEK LA	ANDLING 12. Was Decedent	Ever in U	.S. 13. V	214 Vas Decede		lispanic Origin? (Sr	pecify Yes or No	UNITED 14. Rac	e - American Inc	dien,
21215-0020	gas 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Itema 23s or 28s-f show or other treumatic event, the Mexical Evarrices must be notified at	2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 I If Yes, Give X Year or Detes:			Yes, speci		lispanic Origin? (Span, Mexican, Puerto Specify:	o Rican, etc.)	Specify	ck, White, etc. WHITE	
5-0	72 ho	Completed by	15. Decedent's Edu (Specify only highest gred	cation e completed)		16a. Deced	ent's Usual	Occup	ation	kina	16b. Kind of B	usiness/Industry	1
21	within lene. the Me		Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	O NOT use	e retired	during most of world)	9			
	Hygien ther th	5	12	2		OWNER	CAR I	EAL	ERSHIP	on (Final Adiabata	AUTOMOT		
and	Mal H	ן מ	17. Father's Neme (First, Middle, Last)						18. Mother's Nan			1 <i>0)</i>	
Maryland	should be and Mental marked o	2	JOHN S. LAYCOCK 19a. Informant's Name/Reletionship (Ty	ran Brint)		10b Mailin	a Addross	(Street	ELIZABE and Number or Ru			State Zin Code	۵)
Ma	d 2 sho th and 7 le me treum	1	DOWNERS HIS TON THE REAL PROPERTY.	36 25		54 E.	•				CH, FLORI		
ē,	permit. Pegas 1 and 2. Department of Health a Important: If Item 27 le any Injury or other treu	l.	ROBERT S. LAYCOCK 20a. Method of Disposition	(SON)	20b. F	Place of Dispos	sition (Nam	e of		Date		City or Town, S	
Baltimore,	permit. Pegas Department of Fimportant: If Ita any Injury or of pncs.	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		cometery, cren LAS CRE				7 24 05	EDGEWAT	יבים אור	
=======================================	artm. Fortar	1	21. Signature of Funeral Servicense		KA				ss of Fecility GEO				HOME
ä	Ped Per Ped) Me	10	-2				ONS ISLA				
		+	23a. Pert1. Enter the disease, or complishock, or heart failure. List only or	ications that caused	the deet							Appr	roximate rvel Between
	Physician /Medical Examiner	1		LIVI	ER. Due to (c		2RH uence of):					Onso	et and Death
	b d ansk		Sequentially list conditions). p4 6. CF		T as a conseq						- 1	
68760,	- O1 60 -	8	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	2.	Due to (c	or as a consequ	uence of):						
Box	endin r use			d								1	
	e daal	Physician	Part II. Other significant conditions cor	ntributing to death b	ut not res	sulting in the ur	nderlying ca	use giv	ren in Part I.	23b. Dld	tobacco use co	ntribute to the	cause of death?
s, P.O.	s that the	by Phy								10	Yes 2□ No	3 Probably	4 D-thknown
Records,	s been s 2 should	Completed								24a. Wes	en eutopsy ormed?	available	utopsy findings e prior to tion of cause 1?
Ä	scarificate has t irector, page 2 s	Ę								10	Y36 2016	1 ☐ Yes	s 2 No
of Vital	clan: artifica sctor,		25. Was case referred to medical examiner?						26. Place of Dea	th (Check only	one)		
<u>></u>	Physician: this cartific ral director,	2	1 ☐ Yes 2 ☑ No	lospital: 1 Inpatie	-	ER/Outpatien		^			idence 6 Oth		
Division o	Attending P or death.	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of Inju (Month, De	ry y Year)	28b. Time of Injury	M 28	Bc. Injui Wor 1 🗌	ryat rk? Yes 2□No	28d. Describe	how injury occur	red	
Divis	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this cardificate ha completely filled in by the funeral director, page:		3 Suicide 6 Could not be determined	28e. Plece of Inj building, et	ury - At h c. <i>(Speci</i> i	ome, farm, str fy)	eet, factory,	office		28f. Location (City or To	Street end Numl wn, State)	er or Rurel Rou	ite Number,
	- Hospi 24 hou Funer letely fill	dicai	29a. Certifier (Check only one) 2 Medical Exami	sician: To the best ner: On the besis of end manner sta	fexamine	owledge, deeth etion end/or inv	occurred e restigation,	in my o	me, date end place opinion, death occu	, end due to the rred et the time,	ceuse(s) and made, date and place,	anner es steted. and due to the	cause(s)
	withir To th	-	29b. Signature and title of certifier						se number		-	d (Month, Day,	*
			Monegi	ms				$\mathcal{V}_{\overline{z}}$	57531		July	22,	2005
			30. Name and address of person who co	empleted cause of d	leath (Iter	п 23a) (Туре,	Print) Hw;	<i>†</i> , .	Miyers	ville	, MD.	21108	
	State		31. Dete filed (Month, Day, Year)	32. Wistr	er's Sign	eture	harth	9					

Physician	1 - State AMEND Item 8 1. Decedent's Name (First, Middle, Last)			2. Date of Death	av Year	3. Time of Death
/Medical	RANDOLPH O	MCI	BRIDE	JULY a	14 2005	1100 AM
Examiner	4a. Facility Name (If not institution, give s	.4	4b. City, Town, or Location of De	eath 4	lc. County of Death	
		PITAL CENTER			WICOMIC	
eral ctor	110-12-1462	x	st birthday) If Under 1 Year If Under 24 H Months Days Hours M Months Days Hours M		u) Logni	ace (State or Foreign ry)
* -	Usuel Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location		10	d. Inside City Limits
be notified a	Md Somers	ET E	deN			Yes 2□No
event, the Medical Exactine must be notified at Be Completed by Funeral Director	10e. Street and Number	52	21822	Ü,	citizen of What Count	tates
Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e	
1 by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1 ☐ Yes 2 ØNo Specify:		Specify: Bi	K
t, the Medical I	15. Decedent's Edu (Specify only highest grade		16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 16b.	Kind of Business/Ind	ustry
du	Elementary/Secondary (0-12)	College (1-4or 5+)	-TO 1/ 500 -			1 .
ပိ	17. Father's Name (First, Middle, Last)		1RUCC DR, VO	Vame (First, Middle, Maid	(GASPURG	NION
Be C		Ride	SAG	21 - 60	11	
To		21	19b. Mailing Address (Street and Number or	Rural Route Number, Cit	v or Town. State. Zip	Code)
other traumatic event, the Manager of the Manager o	DIANNE MC	BRILL	5634 CA. PUS DR	1/A 60	el vet	13417-
	20a. Method of Disposition	20b. Pla	ce of Disposition (Name of	Date 20c.	Loca ion - City or To	wn, Stern
	1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	removal from State	netery, crematory or other place)	rolar N	VOLES 11	A
any injury or QDC8.	21. Signaruje of Funeral Service License	1 100	22. Name and Address of Facility	625 MA	distant A	vi
900	Edger Kil	Who arlow	GRAYS E/14	CARO	Charles	VA
	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the deeth. ne cause on each line.	Do not enter the mode of dying, such as card	fiac or respiratory arrest,		Approximate Interval Between Onset and Death
ian	Immediate Cause (Final disease or condition	END STAGE	RENAL FAILURE			Onset and Death
er er	resulting in death)	Due to (or as e conseque	ince of):			
	Sequentially list conditions.	b. Dialderes Due to for as a conseque	MELLITUS			
Examiner	Sequentially list conditions, and badden to the cause. Enter Underlying Cause (Disease or injury	one of the east of a mortion			***************************************	
xar	that initiated events resulting in death) Last	c. Due to (or as a conseque	nnce of):			
42		d				
use use	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand			23d. Date of delive	ry
y Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown			Month	Day Year
F.		atributing to doub but not excult	ing in the underlying cause given in Part I.	23a Did tabasa	o use contribute to th	a source of death?
	HYPERTENSION		ang an the universality cause given in Fart.		2 12 No 3 □ Prob	
0 0	1111000000					
hould be	77-2 1/4	de a bio.				osy findings available appletion of cause of
pleted b	PERIPHERAL VI	4SCULAR DISE	745E	24a. Was an autopsy	prior to con	
pleted b		ASCULAR DISE	ASE		prior to con death?	2□ No
2 should be pleted b	25. Was case referred to medical examiner?	Hospital:	26. Place of	autopsy performed: 1 Yes 2 2	prior to con death? No 1 ☐ Yes	
pleted b	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Yes} \)	Hospital: 1 ☐ Inpatient 2 ☐ E	26. Place of l P/Outpatient 3 □ DOA Other: 4 ☑ Nursin	autopsy performed: 1 Yes 2 W Death (Check only one) g Home 5 Residence	prior to condeath? No 1 Yes 6 Other (Specify	
To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 ☐ Inpatient 2 ☐ E.	26. Place of I R/Outpatient 3 DOA Other: 4 Nursin 28b. Time of Injury Work?	autopsy performed: 1 Yes 2 2	prior to condeath? No 1 Yes 6 Other (Specify	
pleted b	25. Was case referred to medical examiner? 1 Yes 2 PNo 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	Hospital: 1 ☐ Inpatient 2 ☐ E 28a. Date of Injury (Month, Day Year)	26. Place of I P/Outpatient 3 DOA Other: 4 Nursin 28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No	autopsy performed 1 Yes 2 197 Death (Check only one) g Home 5 Residence 28d. Describe how in	prior to condeath? 1 Yes 6 Other (Specify	·)
rector, page 2 should be Be Completed b	25. Was case referred to medical examiner? 1	Hospital: 1 ☐ Inpatient 2 ☐ E 28a. Date of Injury (Month, Day Year)	26. Place of I R/Outpatient 3 DOA Other: 4 Nursin 28b. Time of Injury Work? M 1 Yes 2 No 1e, farm, street, factory, office	autopsy performed 1 Yes 2 197 Death (Check only one) g Home 5 Residence 28d. Describe how in	Prior to condeath? No 1 Yes 6 Other (Specify nijury occurred	·)
rector, page 2 should be	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient 2 E 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hom building, etc. (Specify) rsician: To the best of my know iner: On the basis of examination	26. Place of I R/Outpatient 3 DOA Other: 4 Nursin 28b. Time of Injury M 1 Yes 2 No 1e, farm, street, factory, office	autopsy performed 1 Yes 2 19 2 19 2 19 2 19 2 19 2 19 2 19 2 1	prior to condeath? 1 Yes 6 Other (Specify injury occurred and Number or Rura ate)	() I Route Number, ated.
rector, page 2 should be Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only ane) 25. Was case referred to medical examined.	Hospital: 1 Inpatient 2 E. 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hom building, etc. (Specify)	26. Place of I P/Outpatient 3 DOA Other: 4 Voursin 28b. Time of Injury M 1 Yes 2 No ne, farm, street, factory, office ledge, death occurred at the time, date and plan and/or investigation, in my opinion, death of	autopsy performed 1 Yes 2 12 Peath (Check only one) g Home 5 Residence 28d. Describe how in City or Town, State, and due to the cause courred at the time, date	prior to condeath? 1 Yes 6 Other (Specifying) occurred and Number or Ruralate) (s) and manner as stand place, and due to	r) I Route Number, ated. the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sea Buewington Meale /Medical **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** 102M 2□F Hours Yrs 212-22-21 3 Maryland Director 1.18 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28e-f ahow the Medical Exercities must be notified at 1V Yes 2 No Director MDCaroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 107 or Itams 23e Street SA ourth Funerai 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Completed by 3 1 Widowed 4 □ Divorced "Black "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) ongShoreMan Seafood Industr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be nd 2 should be fi lith and Mental H 27 Is marked ot r traumatic ever urtis Mealey 2 Wave Queen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ct. Apt. J-Glenburnie MD 21061 7889-tall Pines hery Youn9 other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department in Important: If any injury or once. 31/05 Sandtown Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Ridgely 22. Name and Address of Facility Hone, P.A. Henry Funeral Hone, P.A. 21. Signature of Funeral Service Licensee 23a. Part1 Inter the disease, or complications that caused the dean. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Days **Physician** bsis Se /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery hed by the attent 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be 1 Yes 2 No 3 Probably 4 Maknown tensio 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ Ŋo 24a. Was an page 2 autopsy 2 2 No 1 Yes Division of Vital Hospitel or Attanding Physicien: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ hpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 🗷 🛱 No 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury after death. 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C Medicai 29a. Certifier Destifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the

State Registrar 29b. Signature and title of certifier

Lakshmi Vaidyanathan, M.D., 219 S. Washington St., Easton, MD

ranathan

2005 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0057

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005^{Year} July 17 **Physician** Antonio 3:43р м Malave /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Funeral 1 **3**M 2 □ F 7944 60 111-34-9227 Director New York Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examinar must be notified at Rockville MD Montgomery 1 TYPS 2 NO Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20850 405 Reading Avenue IISA itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married ☐Yes 2 No Yes, Give Saltimore, Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates "naturai", 16a. Oecedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any niuro other traumatic event. The Mudic once. Elementary/Secondary (0-12) College (1-4or 5+) Property Manager Real Estate 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hilda DeJesus Antinio Malave 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gail Malave/Wife 405 Reading Avenue Rockville, Md 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethel Mem.Park 7/22/2005 Pennsauken, N.J. `4 □Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licensee PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Se Durck /Medical Due to for as a consequence of): **Examiner** trolco Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Gisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed gorticulve replagment perati attending physician for use as the burial Division of Vital Records, P.O. Box 68760, coronarydisease Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be Imper 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 2∏ No 1 Yes or Attending Physician: after death. I **Diractor:** After this certifica d in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 1 XYes 2 ☐ No 3 □ DOA | Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Pelli To the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 18, 2005 30. Name and address of person who completed cause of death Item 23a) (Type, Print) 7600 Carrol Avenue Takoma Park, Md 20912 Anjum Quzi MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 6 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Mark Haddaway McWilliams 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambridge
If Under 1 Year If Under 24 Hrs. Hospital Dorchesters beneral Dorchester 8. Date of Birth (Month, Day, Year)
May 25, 19 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 15 M 2 T F 55 Yrs. 212-56-1078 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Dorchester Church Creek permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28e-1 any injury or other traumatic event, the Medicial Evantinal must be routing once. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1911 White Haven Drive 21622 **USA** Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Baltimore, Maryland 21215-0036 $^{\prime\prime}$ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel McWilliams Jane Todd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Marie McWilliams/Spouse 1911 White Haven Dr., Church Creek, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State EastNewMarketCemetery 07/29/05 * 4 □ Donation 5 □ Other (Specify) East New Market, MD 22. Name and Address of Facility
Curran-Bromwell Funeral Home, P.A. Signature of Funeral Signature Licensee 308 High St., Cambrete the mode of dying, such as cardiac or Cambridge, MD as cardiac or respiratory arrest, 23a Part1. Enter the disease or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10carain /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifi

mens

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

DHMH 17 Rev 1/2001

Michelle Parsons, M.D., 219 South Washington St., Easton, MD

32. Registrar's Signature

0060095

29d. Date signed (Month, Day, Year)

2005

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	Funeral Director		5. Social Security Number 219-40-8156 6. Sex	7. Age (In yrs. last birthda 62 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 11	Year) 194	Col	nplace (State or Foreign untry) Cyland
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The la	certificate has rector, page 2	Completed					autops perform 1 Yes	med2 2 No	prior to death?	completion of cause of
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e Phy	h. After this funeral di	\vdash	27. Mannet of Death 28a.	Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury		28d. Describe ho			iny)
ttendir	tor: Af	catic	Accident 5 Pending 2 Accident 1 Accident 3 Suicide 6 Could not be 300		M 1 🗆 Y	es 2□No	004 1 (0			
ital or A	within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	4 Homicide determined 289.	Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		City or Town		umber or Hu	ral Route Number,
9 Hosp	e Fune letely fi	Medical	(Check only 2 Medical Examiner: On	To the best of my knowledge, de the basis of examination and/or d magner stated.	ath occurred at the tim- investigation, in my op	e, date and place, inion, death occur	and due to the cared at the time, d	ause(s) an ate and pla	d manner as ace, and due	stated. to the cause(s)
To th	withir To th comp	Me	29b. Signature and title of certifier		29c. License	number	2	9d. Date	igned (Month	Day, Year)
			30. Name and address of person who complete	t cause of death (Item 23a) (Tvo	ne Arint)	1	7	11	10	L
			Steven 1	esuite 1	Hure F	nul	S) /76-	1(cd	Cer	en
	. Sta Registr		31. Date filed (Month, Day, Year) JAN 2.6 2005	32. Redistrar's Signature	And.					

			1 - For State Registrar	State of Maryla		artment of I		Re	g. No. U U 5	26013
	Obvois		1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	_	3. Time of Death
	Physic /Medi		MARGARET MAR	Y MILAN				AUGUST		
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Deat	ר	4c. County of [Death
			63 HIGHLAND PL				N HEAD		CHAR	
	Funeral		5. Social Security Number 6. Se	9x 7. Age (In yr □M 2⊠F	rs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		173-24-0943 Usual Residence of Decedent	- H	7.3 Yrs.			DEC. 26,	1931	PA
	land		10a. State 10b. County	10c.	City, Town or Li	ocation				10d. Inside City Limits
	72 hours atter death with the Maryland natural', or Itams 23a or 28a-1 show aloal Examilinat authorinatified at	ō	MARYLAND CHAR	T DC	TNIDT	7 11 11 7 7				1 ☐ Yes 2 🏋 No
	28a-	Funeral Director	MARYLAND CHAR 10e. Street and Number	LES	INDI	AN HEAD 10f. Zip Code		10	g. Citizen of Wha	t Country?
	with Se or	0	63 HIGHLAND PL	7 .			0640			
	leath	era	11. Marital Status	12. Was Decedent Ever in	1 U.S. 13.		0640 Hispanic Origin? (S	pecify Yes or No-	.14. Race - /	American Indian.
10	fter c	E	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2k∏XNo			Hispanic Origin? (S pan, Mexican, Puert	o Rican, etc.)		Vhite, etc.
3	urs a	þ	3X□XWidowed 4 □ Divorced	If Yes, Give "" Year or Dates:		1☐ Yes 2☒ No	Specify:		Specify:	WHITE
Õ	2 ho	ted	15. Decedent's Ed	ucation		dent's Usual Occu		11	6b. Kind of Busin	
27.	within 7 ene. than "n	Be	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	Nind of work done DO NOT use retire	i during most of wor ad)	King		
21215-0036	gienr gienr greath	Completed	10		ном	EMAKER			OWN_H	OMF.
	e file al Hy oth vant	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M		01111
<u>a</u>	nould be if Mental narked o	101	JOHN NAHAY				CATH	ERINE V	TARGA	
Maryland	2 sho and 1 Is ms	ľ	19a. Informant's Name/Relationship (7	уре, Print)	19b. Maili	ng Address (Stree		ral Route Number,	City or Town, Sta	te, Zip Code)
_	ges 1 and 2 should be filed within 72 hours after death with the Marylar to Health and Mental Hygiene. If Itam 27 is marked other than "natural". or Itams 23a or 28a-1 show or other traumatic event, the Medical Examinating the notified.		RACHEL ARGO-DAI	JGHTER	144	46 KILL	ENS PON	RD. B	ARRING	FON.DE 19952
ore	of He		20a. Method of Disposition		o. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)		0c. Location - City	
Ĕ	Page nent int: II		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		-	-	TORY 8-	5_05	LEXAND	T. N. W.
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Fureral Service Licen		(2	2. Name and Addre	ess of Facility			
Ö	Depared Important any in		Much	1				SERVIC		
			23a. Part1. Ent if the disease, or composhock, or heart failure. List only	olications that caused the de	eath. Do not en	ter the months of	ng! such a china	Fratory and	646	Approximate Interval Between
	Physician		Immediate Cause (Final	Pancr	· 4.	Canc	2 ~			Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a cons		010	0			743,004)
	Examiner									*
		je.	Sequentially list conditions, if any, leading to immediate cause. Linter Vincertying Cause (Disease or injury	b. Due to (or as a cons	equence of):					
$\sqrt{}$	cuted	Examiner	Cause (Disease or injury that initiated events	c						
o,	ate be executed hysician and the burial-transit	EX	resulting in death) Last	Due to (or as a cons	equence of):					
8760,	ite be iysici ne bu	cal		d						
9	tifica ng ph as th	P	The second secon							
Вох	death certifica attending ph d for use as th	an/N	23b. was decedent pregnant	23c. If yes, outcome of preg		DEctopic pregnanc	עי		23d. Date of	,
	deal	sicia	in the past 12 months? 1 Yes 2 No	4□Pregnant at time of		Other (specify)			Month	Day Year
P.0	that the de led by the a detached	Physician/M	9 ☐ Unknown `							
	Se us	by F	Part II. Other significant conditions co	ntributing to death but not r	resulting in the u	inderlying cause gr	ven in Part I.	23e. Did toba	V	te to the cause of death?
ord	w requir been si should							1 🗀 Yes	2 No 3	Probably 4 Unknown
Records,	e law re has be je 2 sh	ompleted						24a. Was an autopsy	24b. Wer	e autopsy findings available to completion of cause of
	The hard	E						perform	ad? deat	h?
Vital	ysician: The is certificate hi director, page	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only one		
f <	Physician: this certific ral director,	2	examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA Ot	her: 4 Nursing H	ome 50 Resider	nce 6 Other (Specify)
ηot	ding Ph. h. After thi funeral		27. Magner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	f 28c. Inju	iry at	28d. Describe how	v injury occurred	
0	Attending r death. sctor: After by the funer	atic	1 Natural 5 Pending 2 Accident investigation		,,		Yes 2□No			
Division	r Atto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, st	reet, factory, office		28f. Location (Stre		r Rural Route Number,
	tal or	Cer		3.						
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my k liner: On the basis of exami	knowledge, deat ination and/or in	h occurred at the to vestigation, in my	ime, date and place opinion, death occu	, and due to the car rred at the time, da	use(s) and manne te and place, and	or as stated. due to the cause(s)
	thin the	Mec	29b. Signature and file of certifier.	and manner stated.		29c. Licen	se number	29	d. Date signed (N	fonth. Day Year)
	F 3 F 8		192	2/ ~	1		3426		8/5/	25
7	^								0/0/	
	8		B (C C / P)	ompleted cause of death (It	tem 23a) (Type,	erint)	Trans	Ann 1	a Plat	L, MS 2064
		nto.	31. Date filed (Month, Day, Year)	32. Registrar's Sig	onature	ical	marge	11cc., L	W IN	2007
	Sta Registi	4	AUG 0 5 20		13. B	2000				

51	53		Unpend item#2	3a, 27, perME, C846, 8/10 State of Maryland, Depart)/05 TT artment of Health and Me	ntal Hygie	ne
		•	For State Registrar		rtificate of Death		N2005 26014
¥	Physici	an	1. Decedent's Name (First, Middle, La		2	2. Date of Death Month	Day Year
5	/Medic	al	Joseph Anthony 4a. Facility Name (If not institution, gir		4b. City, Town, or Location of Death	JULY :	31, 2005 1854 P M
	Examin	er	2021 BONNIE LANE		WALDORF		CHARLES
	Funeral			Sex 7. Age (In yrs. last birthday) 1 XM 2 F 61 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Y uly 22,	9. Birthplace (State or Foreign Country) Washington DC
7	Director		Usual Residence of Decedent			uly ZZ,	
	show	ò	10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 🂢 No
	the N	Funeral Director	Maryland Charles 10e. Street and Number	s Wald	10f. Zip Code	10g	. Citizen of What Country?
	23a o	alD	2121 Bonnie Lane		20601		USA
	iteme iteme	nue	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1/□Yes 2 □No	Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
920	ours aff	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
15-0	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f show he Medical Examiner must be indiffied at	Completed	15. Decedent's E (Specify only highest gi	Education 16a. Dece rade completed) (Give	dent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16	b. Kind of Business/Industry
212	e filed within al Hygiene. I other then '	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	outer Programmer		ommunications
ng	be filed tal Hygi d other event, t	BeC	17. Father's Name (First, Middle, Las	st)	18. Mother's Name		iden Surname)
Baltimore, Maryland 21215-0036	Men Men arke	ို	Joseph K. Moran 19a. Informant's Name/Relationship	(Type Print) 19b Maili	Vivian Aming Address (Street and Number or Rural		City or Town, State, Zip Code)
Ma	1 and 2 sho Health and Iom 27 io m		Vivian Moran - Mo	0.00	Bonnie Lane, Waldo		
ore,	ges 1 a it of Hea iff item or othe		20a. Method of Disposition 1 ☑ABurial 2 ☐ Cremation 3	☐Removal from State	osition (Name of Damatory or other place)		c. Location - City or Town, State
E	Pa men ury		4 Donation 5 Other (Spec	Ft. Linco	oln Cem. 8-5-0 2. Name and Address of Facility		adensburg, MD
Ba	pe mit. Departi Import		Jack A. W	HOILTO	Huntt Funeral Home	P. O. B Waldorf	
· · · 57	\$	1	23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused the death. Do not en by one cause on each line.	ster the mode of dying, such as cardiac or	respiratory arres	t, Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	ardiovascular Disea	se	Olisot und Bouth
	/Medical Examiner			Due to (or as a consequence of):			
	P #	ner	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Oue to (or as a consequence of):			
_	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):			
760,		calE		d			
89	leath certificat attending phy I for use as the		IF FEMALE:				
Вох	eath ce attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
P.0.	that the de led by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		1	
	86 69	þ	Part II. Dther significent conditions	s contributing to death but not resulting in the u	underlying cause given in Part I.		cco use contribute to the cause of death? 2 \[\sum No \] 3 \[\sum Probably \] 4 \[\sum 0 \] nknown
Records,	w require been si should I	Completed				24a. Was an	24b. Were autopsy findings available
Re	The lav	mo				autopsy performe 1 XYes 2	prior to completion of cause of death?
Vital	Physicien: The this certificete har director, page	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death		V COENTE
o		5	1 ØYes 2 No 27. Manner of Death	28a. Date of Injury 28b. Time of	ant 3 DOA 4 Nursing Horr	e 5 ☐ Residen 8d. Describe how	ce 6 Wother (Specify) SCENE
ion	Attending or death.	atlor	1 X Natural 5 ☐ Pending investigat	1	M 1 Yes 2 No		
Division	or Attuater de Directo	Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	8f. Location (Stre City or Town,	et and Number or Rural Roule Number, State)
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying	Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, a	nd due to the cau	ise(s) and manner as stated.
	To the Ho within 24 I To the Fu completely	Medical	one)	aminer: On the basis of examination and/or in and manner stated.			
	To To	2	29b. Signature an Mitte of certifier	In Th	29c. License number OCME		d. Date signed (Month, Day, Year) JGUST 1, 2005
			30. Name and address of person wh	no completed cause of death (Item 23a) (Type			_,
-			S.R. 1406	111 P	ENN STREET, BALTIMO	RE, MARY	ZLAND, 21201
4	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 0 9 2	32 Registrar's Signature	ante		

			1 - For State Registrar	State of Maryl	-	artment <i>rtificate</i>			ind Me		giene	0.05		26015	<u>.</u>
	Physicia /Medic	an	Decedent's Name (First, Middle, Last) WILLIAM ALAN MO							2. Date of Dea Month JULY	Day		ear 005	3. Time of Dea 6: 27A	14
	Examin		4a. Facility Name (If not institution, give s PRINCE GEORGES HOS		ER	4b. City, T		Location of				County of PRIN		EORGES	
	Funeral Director		225 66 7695	7. Age (In	yrs. last birthday) 61 Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day JULY 28	v, Year)	9		ace (State or For ry) INGTON,	
	Maryland f show	ō	Usual Residence of Decedent 10a. State 10b. County VIRGINIA CULPEPER		. City, Town or Lo								10	0d. Inside City Li	
	vith the P	Director	10e. Street and Number		IEFFERSU	10f. Zip (Code					zen of Wha			
356	J within 72 hours after death with the Maryland jiene rithe. The Medical Examinations Le modified at	by Funeral	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	ROAD 12. Was Decedent Ever Armed Forces? 1 Yes	in U.S. 13.	Was Decede If Yes, specific Yes, Specific Yes	fy Cuba	227 spanic Orig n, Mexican Specify:	in? (Spec	cify Yes or No- lican, etc.)	. 1	TED 4. Race - Black, Specify:	Americ White,	an Indian, etc.	
21215-0036	filed within 72 hou Hyglene. other than "nature ent, the Medical E	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give	edent's Usual skind of work DO NOT use	k done d e retired	turing most	of workin	g	16b. Kir	nd of Busin			
	be filed ital Hyg id othe event,	To Be Co	12TH 17. Father's Name (First, Middle, Last) HOWARD EPHRATM MOI	RRIS		DRIVER				(First, Middle,		Sumame)	IAVI	. <u>r</u>	
Maryland	C1 10 - 10	-	19a. Informant's Name/Relationship (Ty			ing Address				Route Numbe				Code)	
			20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ F	Removal from State	Db. Place of Disp cemetery, cre	osition (Namematory or other	e of her plac	e) 1	Da	ate	20c. Lo	cation - Ci	ty or To		
Baltimore,	permit. Page Department of important; if any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Fune () Service Licens			2. Name and FOUND	Addres	SON SON	s FUI	NERAL C KE CUL	CHAPE	EL		NTON, V	Α
	Pnysician		23a. Part1. Enter the disease, or compleshock of heart failure. List only of Immediate Cause (Final		death. Do not en	iter the mode						41C9 V		Approximate Interval Between Onset and Deat	n th
	/Medical Examiner		disease or condition resulting in death)	a. CEREBRAI Due to (or as a cor CEREBRAI	nsequence of):		NCT C								
8760,	ate be executed hysiclen and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nesquence of):	SOLERC	7515								Yanaw
Box 6	deeth certific e attending p ed for use as 1	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pre					2	23d. Date (Month		ry Day Year	r
ds, P.O	uires that i signed by id be deta	by	Part II. Other significent conditions co	ntributing to death but no	t resulting in the	underlying ca	iuse give	en in Part I.						e cause of death ably 4 □Unkr	
Records,	The law requires that the rate hes been signed by the page 2 should be detache	Completed								24a. Was autor perfo 1 🗆 Yes	an osy rmed? XX No	pride	ore auto or to con ath? Yes	osy findings avai npletion of cause 2 No	lable e of
Division of Vital	Attending Physician: The Ir death. ector: After this certificate he ector: After this certificate he by the funeral director, page	tion: To Be	27. Manner of Death XXNatural 5 Pending	Hospital: XX Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie	7	Bc. Injun Worl	er: 4 □ Nu y at	rsing Hom	(Check only one 5 ☐ Resident	dence 6			′)	
Division	ai or Attendation after death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, s pecify)	treet, factory,	, office		2	8f. Location (City or Tou			or Rura	l Route Number,	
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical C		rsicien: To the best of my iner: On the basis of exa and manner stated.											
,	To the within 2 To the complei	M	29b. Signature and title of certifier	-100				e number	62					Day, Year)	05
2	(10)		30. Name and address of person who c	ompleted cause of death		, Print)									
	Sta Regist		SHERIF HASSAN, M 31. Date filed (Month, Day, Year)	Registrar's S	B1 GREEN		W	11 1 0 3	LAI	NHAM, M	<u>u</u> ∠0	700			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY 21 Day 200 5 6:00 pM **Physician** MENEFEE SELITHA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES BOWIE 15601 POWELL LANE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month Day, Year)
10-02-1943
AIKEN, S.C. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1□M 250F Yrs. 249-74-1002 61 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 1 TyYes 2 □ No Director PRINCE GEORGES BOWIE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20716 15601 POWELL LANE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exalt 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 Specify: à 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) BALTIMORE CITY College (1-4or 5+) Elementary/Secondary (0-12) DEPT. OF EDUCATION EDUCATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MEACHAM NOBLES THELMA GEORGE W. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HUSBAND MICHAEL AARON MENEFEE -15601 POWELL LANE, BOWIE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/27/05 LAUREL, MARYLAND MD NATIONAL CEM. • 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Inneral Service Licent e TAYLOR'S FUNERAL HOME 722 NORTH CAPITOL ST., NW WASH.DC 20001 23a. Part1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician AMYOTROPHIC NOTERAK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea: 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 9 Unknown 9 Hlnknown been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CARDIOVASCULAR 1 Yes 2 No 3 Probably 4 Unknown HYPERTEUSIUE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an OBSTRUCTUE autopsy performed? (es 2 X No has 1 ☐ Yes X☐ No 1 Yes certificate To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 28d. Describe how injury occurred 28b. Time of 27 Manner of Death I Director: After to id in by the funeral Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel I 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D28079 30. Name and address of person who completed cause of deam (Item 23a) (Type, Print) BECTSULLIE MARYLAND 20705 BELTSVILLE 11700 DRIVE Registrar's Signature 31. Date liled (Month, Day, Year) State JUL 2 6 2005 Registrar

Amend item#5, perFH, \$846,8419/05 II Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 5:15 PM F. McCauley **Physician** Eunice 2005 Julv/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Adventist Hospital Takoma Park Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Many 29, 1 9 | 9 | 9 | 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 578*30*1366 **Funeral** Months Anderson Co., SC 1 □ M 2 1 F 86 Yrs Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location or 28e-f ehow f Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28e-f ehov other treumatic event, the Madical Examble in must be redified at 1 No 2 No Washington DC Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with United States 1909 Varnum Street NE 20018 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes **& No** If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify: Black 3 ₩Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elise Williams Benjamin Williams 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hyattsville, MD 20784 4711 Rockford Dr John Ellis (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō = 1 № Burial 2 Cremation 3 Removal from State ŏ 7/29/2005 Ft. Lincoln Cemetery Brentwood, MD permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature Funeral Service Licensee 3401 Bladensburg Road Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 🛣 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral 28b. Time of 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending 1 TYes 2 🗌 No investigation death. Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide To the Hospitel within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) StwM 3415 MD 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar		aryland / Depa	artment of rtificate of		Reg	ene 2005	26018
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Las Gilio Jack Ostj 4a. Facility Name (If not institution, give	<u></u>		4b. City, Town,	or Location of Dea		Day Year 4, 2005 4c. County of Dea	3. Time of Death 10:23 a M
	Funeral Director		162-14-4545		ge (In yrs. last birthday) 83 Yrs.	Silver If Under 1 Year Months Days		n. (Month, Day, Y		nery thplace (State or Foreign ountry) unsylvania
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336	u within 72 hours after death with the Maryland iene. iene. rthan "natural", or items 23a or 28a-f ehow than Madical Examinar must be rodified at	by Funeral Dire	11100 Easecrest 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Drive 12. Was Decedent Armed Forces? 1 Tayes 2 Ulif Yes, Give Year or Dates:	No	10f. Zip Code 2090 Was Decedent of If Yes, specify Cul 1 Yes 2 🗷 No	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	USA 14. Race - Ame Black, Whit	erican Indian, te, etc.
21215-0036	y within jiene. r than "	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give life.	dent's Usual Occu kind of work done DO NOT use retire icklayer	during most of w	orking	Sb. Kind of Business Masonry	/Industry
פ	2 should be filed and Mental Hygis ie marked other eumatic event,	To Be (17. Father's Name (First, Middle, Last) Anthony Osti 19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Stree	Anna	ame (First, Middle, Ma Dalini Rural Route Number, C	uiden Sumame)	Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any njuweanher treumatic ev once.		Rose Marie Osti/ 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify) 21. Six ure Funeral Service Licenses	Removal from State	20b. Place of Dispo cometary, crea Gate of He	D Easecre sition (Name of natory or other pla aven Cemet 2. Name and Addr cancis J	est Drive	e, Silve <u>r</u> ; Date 20 1ly 29, 2005 S:	Spring, Ma lo Location - City or ilver Spr:	aryland 2090 Town, State ing, Maryland
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	1041		30. Name an address of person who com. Wajeed Krian,	·	leath (Item 23a) (Type. 2016 Georgi		, Wheato		Tuly 24	,2005
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 6 200	3# Registra	ar's Signature	di)	,	, 112 2000		

			State of Maryland / Department of Health and Mo	ental Hyg	iene	
			1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of Deat	eg. No.2 5	26020
	Physicia		Alvin Lee Palmer	Month	20 2005	0621 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	July	4c. County of De	
			Peninsula Regional Medial Center Salisburg		NICON	7/0
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		218-40-5649 63 Yrs. Usual Residence of Decedent	6-7-194	2	Md.
	yland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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	eath v	erai	6721 De1mar Road 19940 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	ofy Voc or No	USA 14. Race - Am	orioga Indian
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8	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: \[\bar{V} \]	Vhite
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Ba	Departiment in police.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E. Grove St. Del	mar Do	100//0	
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٥٥		⊢ .	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28		w injury occurred	eny)
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	Funeral Director		5. Social Security Number 6. Sex 198-05-5036	M 2½F 7. Age (I	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours	Min. 8. Date of Bir (Month, Da	ay, Year)	9. Birthp Cour PENN:	place (State or For htry) SYLVANIA	reign
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	the N	rect	MARYLAND MONTGOMER 10e. Street and Number	Υ	ROCKVILLI	10f. Zip Code			10g. Citizen of	What Cour		
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900	ours after ural', or l	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	I□Yes 2【X No	Specify:		Specif	52:	WHITE	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, It is Medical Examination and investments.	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life. I	lent's Usual Occup kind of work done o DO NOT use retired	ation during most o f)	of working	16b. Kind of B	usiness/Ind	dustry	
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O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				te of delive	ry Day Year	
<u>a</u> .	that the ned by detac	by Ph	Part II. Other significant conditions contri	ibuting to death but n	ot resulting in the ur	iderlying cause give	en in Part I.	23e. Did to	obacco use cont	ribute to th	e cause of death?	?
ords	w requires that the been signed by th should be detache							101	Yes 2 ☐ No	3 Proba	ably 4 □Unkno	own
Vital Hecords,	The faw ate has b page 2 s	Completed				-		24a. Was autop perio 1 ☐ Yes	osy rmed?	prior to con death?	osy findings availanted and a second control of cause and a second control of cause and a second control of the second control of th	ible of
II a	ılcian: Th certificate rector, paç	Be (25. Was case referred to medical examiner?					Death (Check only o	nne)			
0	Phys this ral dii	2	1 Yes 2 No	spital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatient	3 DOA Othe	or: 4 Nursi	ing Home 5 Resid)	
	th. : After s funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye		28c. Injury Work	rai (? Yes 2∐No		now injury occur	ea		
Division	ul or Attanding after death. I Diractor: After d in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (\$	- At home, farm, stre Specify)	eet, factory, office		28f. Location (5 City or Tow	Street and Numb vn, State)	er or Rural	Route Number,	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	r: On the best of m	amination and/or inv	occurred at the tim	e, date and pointion, death	place, and due to the occurred at the time,	cause(s) and ma date and place,	inner as sta and due to	ated. the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	d (Month, L	Day, Year)	
	2	14	U	MP		D	006	1096	07/2	-3/0	5	
			30. Name and address of person who com Usha Gollapalli, M.)., 15225	Shady Gro	ve Road,						
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 6 2005	32 Registrar's	Signature	ule)						

			For State Registrar	State of M	1arylan		artmen <i>tificat</i>			and M		giene	005	26022
	Physici		Decedent's Name (First, Middle, L William	ast)	Jose	ph		Pep	per		2. Date of Dea			3. Time of Death 12:10 M
	/Medic Examir		4a. Facility Name (If not institution, g. Holy Cross H		r)				Location o			4c. Co	ounty of Death ontgor	1
	Funeral Director		579-22-3636	Sex 7. A 1(XM 2□F	ge (In yrs. i	last birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birth (Mgnth, Da) 2 / 2 6 /	1 [°] 9′21	9. Birth	place (State or Foreign intry) N . Y .
	faryland show	or	Usual Residence of Decedent 10a. State 10b. County MD MOntgo	omery		y, Town or Lo		ing			-			10d. Inside City Limits 1 ☐ Yes 2 No
	with the A sa or 28a-1 Le nefff	i Direct	10e. Street and Number 12824 Lacy Dr	rive			10f. Zip	Code 209	0 4			-	of What Cou	intry?
920	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Medical Exert I. wir must be trafffed at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces	? 19	427	Was Deced f Yes, spec 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto i	ecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White	
21215-0036	f within piene.	Completed	15. Decedent's (Specify only highest g		r 5+)	16a. Deced (Give life. I Cont	kind of wo DO NOT u:	rk done d se retired	uring most	t of workin	oloyed		of Business/I	
ਲੂ	othe Othe Jent.	To Be C	17. Father's Name (First, Middle, Las unobtainable	st)							(First, Middle, cine No		mame)	
Mary	nd 2 should be alth and Mental 27.1s marked or r traumatic av		19a. Informant's Name/Relationship Marion E. Pepp	_							Route Numbe Silver	-		ip Code) d 20904
Baltimore,	Pages 1 and the notes of the no		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from Stat	1 0	Place of Dispo emetery, crem Chesap	natory or o	ther clace	em. 7		/ 0 5		tion - City or 1 tsvil.	
unobtainable Second Catherine Notan														
U	Pnysician		23a. Part1. Enter he disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each	line.	b. Do not ent				cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a										
	acuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a					,					
8760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or a	is a consequ	uence of):								
.O. Box 6	death certif e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	Ideath 3	Ectopic pr Other (sp					230	I. Date of deliv Month	very Day Year
Ω.	quires that the signed by ald be detacted.	by	Part II. Other significant conditions	contributing to death	but not rest	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did to			the cause of death?
Vital Records,	:. The law requires that the icate has been signed by this page 2 should be detache	Completed									24a. Whas a autop perfor 1 ☐ Yes		24b. Were aut prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
Vita	Phyaician: Th this certificate ral director, pag	о Ве	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No	Hospital: 1 Inpa	tient 2	ER/Outpatien		Othe			(Check only or ne 5 ☐ Resid		Other (Spec	76.1
ion of	Ing After une		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigat	28a. Date of In (Month, D		28b. Time of Injury	_	8c. Injury Work	at	2	28d. Describe h			
0.70700	- a	Certification:	3 ☐ Suicide 6 ☐ Could not determine		njury - At ho etc. <i>(Specif</i>)	ome, farm, str	eet, factory	/, office		4	28f. Location (S City or Tow		lumber or Rui	ral Route Number,
	To the Hospital c within 24 hours at To the Funeral c completely filled in	edicai	29a. Certifying I (Check only one) 1 Certifying I 2 Medical Ex-	Physician: To the bes aminer: On the basis and manner:	of examina	wledge, death tion and/or in	occurred vestigation	at the tim , in my op	e, date an inion, dea	d place, a th occurre	and due to the c ed at the time, c	ause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)
V .	To t To t COM	N	29b. Signature and title of certifier	V M	D.		290	D55	number 522		2		igned (Month 1 y 24	
+			30. Name and address of person where Robert Gera	o completed cause of and MD	death (Item 13	00 Fo	rest	Gle	en Ro	d Si	lver S	Sprin	ıg,Md	20910
	Sta Regist		31. Date filed (Month, Day, Year) JUL 2 6	2005 32 Regis	strar's Signa	ture do	uli							

State of Maryland / Department of Health and Mental Hygiene 1 - Stata Ragistrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 2005 ear **Physician** Jüly 22, Charles 10:50P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Somerford Place Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 1, 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min 1 ₹ M 2 □ F 85 Yrs. 338-14-9718 Illinois Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits 28e-f show 27 is marked other than "natural", or Itams 23a or 28e-f shov traumatic evant, the Madical Experiment aust be notified at Anne Arundel Davidsonville Maryland 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2523 Howard Grove Road 21035 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: WWII Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. ģ White 3 X Widowed 4 ☐ Divorced is 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Itam 27 is marked other than "natural; 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Brick and Stone Mason Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Michael Puher Repina Suda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2523 Howard Grove Road Davidsonville, Md. 21035 Paul G. Puher -son r injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important; If its
any injury or ot 1 Burial 2 Cremation 3 Removal from State Arlington National Cemetery 8/18/2005 Arlington, Va. 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA Dorald 200 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final meumon Enysician disease or condition resulting in death) /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as Examiner ed by the attending physician and detached for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physiclan/Medical JF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? disease, colon cancer, 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed -temporal 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? econ 2 No Division of Vital 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of leat 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospitel or Attending I within 24 hours after death.
To the Funeral Director; After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my κnowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ∠9a. Centrier Medical (Check only one) 29b. Signature and title of certifier 10 ans Highway melessille up Name and address of person who completed cause of death (Item 23a) RICO 31. Date filed (Month, Day, Year) State JUL 2 6 2005 Registrar

			1 _ State	partment of Health and Menta	0000	2021
			Registrar 1. Decedent's Name (First, Middle, Last)		Reg. No. U U 5	3. Time of Death
	Physicia		Frank J. Ponce, Jr.	Mod		10:35 a M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dear	
			Bedford Court Assisted Living	Silver Spring	Montgom	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min. (Mo.	nth, Day, Year) Co	thplace (State or Foreign
	Director		Usual Residence of Decedent	Apr	il 17, 1929	New York
	nylanc how		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Be-f s	Director	Maryland Montgomery Silver			1 ☐ Yes 23€ No
	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28e-f show for Madical Examinar must be indiffed at	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	ountry?
	ns 23	Funeral	3701 International Drive, Apt. 344 11. Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Specify Ye	USA s or No. 14. Race - Ame	erican Indian,
മ	or Item		Armed Forces? 1 □ Never Married 2 □ Married 1 🖾 Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto Rican, e 1⊠ Yes 2□ No Specify: Mexican	etc.) Black, Whit	e, etc.
2-0036	iral', c	d by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates: WWII	1M Yes 2□ No Specify: Fig. 11Cd1	Specify: Wh:	ice
2	"natu	Completed	(Specify only highest grade completed) (Gi	edent's Usual Occupation re kind of work done during most of working . DO NOT use retired)	16b. Kind of Business	/Industry
2121	withir ene. then	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	cofessor	Education	2
9	filed v I Hygie other t	യ	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,		.1
/lar	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "natural", or items 23a or 28e-f show eumetic event, it a Medical Examinating must be indiffed at	To B	Francisco J. Ponce, Sr.	Florinda L	ino	
Maryland	ges 1 and 2 should t of Health and Mer If Item 27 Is marke or other treumetic			iling Address (Street and Number or Rural Route	-	
	ges 1 and 2 it of Health if Item 27 I	1		Position (Name of Date	ver Spring, MD 20c. Location - City or	
nor	Pages ment of H ent: If Ite		1 Burial 2 □ Cremation 3 Removal from State cemetery, c Management	ematory or other place) Cemetery July 2 2005		
altimore,	permit. Page Department of Importent: If eny injury or once			22. Name and Address of Facility Trancis J. Collins Fund		New Dersey
ä	in per		Denja W. Silm	500 University Blvd, W	eral Home Inc. Silver Sprince	a. MD 20901
			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.			Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition Coronary Artery I	Disease		Onset and Death Years
	/Medical Examiner		Due to (or as a consequence of):			
		P.	Sequentially list conditions, b. Due to (or as a consequence of):			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
o,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d			
9 ×	eath certific attending pl	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		22d Date of de	livon
Box	atten affor u	Physician/M	in the past 12 months?	B Ectopic pregnancy C Other (specify)	23d. Date of de Month	Day Year
P. 0.	at the de by the a tached	hysi	9 Unknown			
	res that igned b	by P	Part II. Other significent conditions contributing to death but not resulting in the Diabetes Mellitus, Colon Cancer	underlying cause given in Part I. 23	e. Did tobacco use contribute to	
ord	w require been si should I		Transcool Merricus, Coron Cancer		1 Yes 2 No 3 Pi	robably 4 KJUnknown
Records,	ne law has b	Completed		24	a. Was an autopsy performed? 24b. Were at prior to death?	utopsy findings available completion of cause of
		e Co	25. Was case referred to medical		Yes 2 Mo 1 Yes	X No
5	ysicien: is certific director,	To Be	examiner? 1 Yes 2X No	26. Place of Death (Checkent 3 DOA Other: 4 Nursing Home 5	Residence 6 2 Other (Spe	cuty) Assisted
Division of Vital			27. Manner of Death 1X Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at 28d. De	scribe how injury occurred	Living
Sio	tendir eath. or: Al	catic	2 Accident investigation	M 1 Yes 2 No		Facility
\leq	i i te	ertification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		ation (Street and Number or Ri or Town, State)	ural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Oi	29a. Certifier 1 CCertifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, and due	to the cause(s) and manner as	s stated.
	he Ho in 24 the he Fu he Fu pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at th	e time, date and place, and due	e to the cause(s)
	To t	2	29b. Signature and fitte of certifier	29c. License number	29d. Date signed (Mont	th, Day, Year)
•	bxl			D38457	July 18, 2	2005
			30. Name and address of person who completed cause of death (Item 23a) (Type Nakul Goyal, M.D. 3801 Internation	e.Print) onal Drive, Silver Spri	ng. MD 20906	
	Sta	te			3,	
ž	Registr	ar	JUL 2 5 2005 Books B. Ap	ule)		

			State of Maryland / Department of He State of Maryland / Department of He Registrer Certificate of D		giene
	hysicia	ın	1. Decedent's Name (First, Middle, Last) Thurman Brocata Perry	2. Date of Dea Month	Day 25 Year 3. Time of Death
Fu	/Medic xamin neral ector	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L DORCHESTER GENERAL HOSPITAL CAME	ocation of Death Or ' dg e If Under 24 H/s. 8. Date of 8 int (Montin, Da)	4c. County of Death DORCHESTER 9. 8 introlace (State or Foreign
Saltimore, Maryland 21215-0036 MM before service after death with the Maryland Department of Health and Mental Mysjene.	or other tr	To Be Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Raymond Name/Relationship (Type, Print) 19. Mailing Address (Street and 19 No III) 19. Mailing Address (Street and 19 No III)	panic Origin? (Specify Yes or No-Mexican, Puerto Rican, etc.) Specify: Ion In most of working Ne Worker 8. Mother's Name (First, Middle, Lille Standard Number or Rural Route Number Avenue Cambo Date	Specify: Black 16b. Kind of 8 usiness/Industry Sea food Industry Maiden Sumame) anley
Phys /Me Exam	dical niner	ner		of Facility NEROLI HOME, P. NOTON ST. CAME Such as cardiac or respiratory an	Aproximate Interval Between Onset and Death
Box 6	detached for use as the burial-transit	ıysician/Medicai Examiner	Cause Disease of Injury Cause Disease Disease of Injury Cause Disease of Injury Cause Disease Diseas	n- area	23d. Date of delivery Month Day Year
cords v requires	should be	Be Completed by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given 25. Was case referred to medical	1 Yas a autor perfor	an 24b. Were autopsy findings available prior to completion of cause of death?
Division of Vita	al Distriction. All of this Confidence has ed in by the funeral director, page 2	Certification; To E	examiner? 1 Yes No Hospital Inpatient 2 ER/Outpatient 3 DOA Other. 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide	at 28d. Describe h	ow injury occurred Street and Number or Rural Route Number,
DIVISIO To the Hospital or Attendivithin 24 hours after death.	completely fill	Medical	Vw V	number	29d. Date signed (Month, Day, Year)
R	Sta egistr	G.	NOME TITANUT 3 N AURURA ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature 34. Aurura ST 4. Aurura ST 5. Aurura ST 5. Aurura ST 6. Aurura	CAOIARIDGE	MD 2/613

	State of Maryland / Department of Health a Certificate of Death									
	1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death								
Physician		Month Dey Year								
/Medical	NATHANIEL PRICE SR • 4a Facility Name (If not institution, give street and number) 4b. City, To	JULY 22,2005 5:45 A. own, or Location of Death 4c. County of Death								
Examiner										
	7221 ODDITIZATE 112	ER SPRING MONTGOMERY								
Funeral	1 NAM 2 F	Min. (Month, Day, Year) Country)								
Director	577-16-6861	FEB. 27, 1916 WASHINGTON								
P	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limit								
n the Marylen r 28a-f show rrotthed at	Total State of the	1 ☑ Yes 2 □ N								
the M	MD MONTGOMERY SILVER SPRING	**								
it a series	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?								
ta 23a	9117 GLENVILLE RD. 20901	USA								
020 urs effer death with the Mau urs effer death with the Mau el', or Herns 23e or 28e-f s Examiner must be recitive by Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Ori	igin? (Specify Yes or No- n, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.								
0 % 2 4	1 Never Married 2 Married 1 Yes 2 No									
ours db	3 ☐ Widowed 4 ☐ Divorced Year or Detes:	BLACK								
Maryland 21215-0020 d 2 should be filed within 72 hours effer death with the Maryland th and Montel Hygiene. 71s marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during mos	at of working								
within see.	(Specify only highest grade completed) (Give kind of work done during mos life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+)									
2 Peri	12 DRIVER	PRIVATE								
ind 2 be filed tel Hygi d other event, tr	17. Father's Name (First, Middle, Last) 18. Mother	er's Name (First, Middle, Maiden Sumame)								
ylan ould be Mentel Mentel out on matter even	ANDREW PRICE	RA JUPITER								
aryla should ind Men marks umeric		er or Rural Route Number, City or Town, State, Zip Code)								
	DELOTS E. PRICE (WIFE) 9117 GLENVILLE R	RD. SILVER SPRING MD 20901								
re, M 1 end 2 1 Heelth 1 Heelth 1 tem 27 l	20a Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State								
Peges nent of int: If its	1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	7/27/05								
altim nit. Per entmen ontant: Injury	LINCOLN MEMORIAL	7/27/05 SUITLAND, MD								
Baltimore, permit. Peges 1 er Department of Hee Important: If Nem 2 any Injury or other once.	21. Signatur, of Funeral Service Licensee 22. Name and Address of Facilities	CEDAR HIBE CONBRAD HOME								
_ 40=40	Nay Hedgman MO1374 4111 PENNSYLVANIA AVE. SUITLAND									
Physician	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	cardiac or respiratory arrest, Approximate Interval Between Onset and Death								
/Medical	Immediate Cause (Final disease or condition a. Congestive Heart Failure									
Examiner	resulting in death) a. Congestive meant Tailure Due to (or as a consequence of):									
ةِ السَّاسَانِ	End Stage Cardiomyopathy									
58760, icete be executed physician end s the burial-transit	U.									
68760, filicate be execu physician end as the burial-trai	Sequentially its conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
68760, ificete be exe g physician es the burial-	triat initiated events Due to (or as a consequence of).									
W + D 0	resulting in death) Last									
Box seth cert for use	d									
C the state of the contract of		Co. Didahan and the same of deat								
O st check by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I									
P.O. that the od by the deteche		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkno								
IN RECORDS, P.O. BOX (The lew requires that the deeth certif sete has been signed by the ettending, page 2 should be deteched for use a Completed by Physiclan/Mo		24a. Was an autopsy 24b. Ware autopsy findings								
or requirement hould		performed? available prior to completion of cause								
lew lew less bases		of death?								
Page page		1 Ves 2 No 1 Yes 2 No								
/ita	25. Was case referred to medical 26. Place	e of Death (Check only one)								
of V hysici his ce il direc	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ No	ursing Home 5 Residence 6 Other (Specify)								
g Ph g rthi eral	27. Menner of Death 1 Natural 5 ☐ Pending (Month, Day Year) 28b. Time of 28c. Injury at Work?	28d. Describe how injury occurred								
Division c tal or attending Pi is after deeth. at Director: After ti led in by the funera Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 ☐ Yes 2 ☐	No								
Division of Vital Records, for Attending Physician: The few requires the effect deeth. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,								
er integral	4 ☐ Homicide building, etc. (Specify)	City or Town, State)								
Division of Vital Rec To the Hospital or Attending Physician: The lew within 24 hours effer deeth. To the Funeral Director: Affer this certificate hes completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date en (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea									
thin 2 the Intrince of the Int	one) and manner stated. 29b. Signature and witte produiting 29c. License number	29d. Date signed (Month, Day, Year)								
5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	29b. Signature and title produiter D0053337	07/26/2005								
	20033331	07/20/2003								
0 (5)	30. Name end address of person who completed cause of death (Item 23e) (Type, Print)									
1-0	Dorothy Seay, M.D. 10801 Lockwood Drive, Suite 2	05. Silver Spring. MD 20901								
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature									
Registrar	JUL 2 6 2005 Perkey & Sante									

DHMH 16 Rev 6/95

DHMH 17 Rev 1/2001

Registrar

2 6 2005

JUL

			1 - State of Maryland / Department / Department / Department / Department / Department / Departm	artment of Health and M			06000
			Decedent's Name (First, Middle, Last)	runcate of Beath	Reg. 2. Date of Death	2005	3. Time of Death
	Physici /Medi		DARLA ELIZABETH RALSTON		Month AUGUST	Day Year 3, 2005	9:48A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			17642 ORIOLE DRIVE	COBB ISLAND		CHARLES	
4	Funeral Director		5. Social Security Number 579-88-1185 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye JULY 24	9. Birth Co. 1959 TE	place (State or Foreign intry) NNESSEE
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ocation			10d. Inside City Limits
	Mary s-f sh	ţō	MARYLAND CHARLES COBB	ISLAND			1 ☐ Yes 2X No
	th the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
	ath wi	ral	17642 ORIOLE DRIVE	20625		U.S.A.	
36	ba filed within 72 hours after death with the Maryland nat Hygiene. Id other then "neturel", or items 23a or 28a-f show event, Ira Middel. Exs. offer cust by notified at	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🛣 No Specify:	city Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: WIH	
21215-0036	72 hou		15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b	. Kind of Business/li	
215	within 7 ene. then "n	Completed	(Specify only highest grade completed) (Give life.	kind of work done during most of worki DO NOT use retired)	ng		GOVERNOR'S
21	a filed within Il Hygiene. other then vent, tre M.			of ADMIN. SERV		SOCIATI	ON
and	I ba fii ntal H ad otl	Be	17. Father's Name (First, Middle, Last) JAMES HARLEY DILLARD		(First, Middle, Maio		
Maryland	2 should ba and Mental is markad eumetic ev	은		VIRGINI ng Address (Street and Number or Rura	A ROSALI		
	5 # 7 F E		ROBERT BORNSCHEIN-HUSBAND 17642				
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: If item 27 any injury or other tre		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, crem	esition (Name of natory or other place)	ate 20c.	AND, MD Location - City or T	own, State
alti	permit. F Departme Importer any injur		TRINITY MEMOR	RTAT, GARDENS 8— 2. Name and Address of Facility	6-05 W	LDORF,M	ARYLAND
ä	Depar Depar Impor	()(market &	RAYMOND FUNERA			
			23a. Part1. Enter the disease, or complications that caused the death. Do not she shock, or heart failure. List only one cause on each line.	er the mode of dying, such as calculated	AND 2000 r respiratory arrest,	46	Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	ANCEN			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
$\sqrt{}$	uted I Insit	Examiner	Cause (Disease or injury				
o,	exection and items	Еха	that initiated events ' c. Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dlcal	d.				
9	artifica ing ph	0	IF FEMALE:	My in			
.O. Box	The law requires that the death certific te has baen signed by the attending p age 2 should be detached for use as s	Physician/M	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
٥.	res that tigned by	y Ph	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
rds	quires n signi uld be	ed by			1 🗆 Yes	2 No 3 Pol	pably 4 ∐Unknown
Records,	The law requir sate has baen si page 2 should	Completed			24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
Vital		0	25. Was case referred to medical	26. Place of Death	(Check only one)	To 1 ☐ Yes	2 □ No
	Q 55 D	To B	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatien	Other	ne F Hesidence	6 ☐Other (Specif	ý)
Division of	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury Injury 28b. Time of (Month, Day Year) Injury		8d. Describe how in		
Sio	tend death tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be 280 Risco of Injury. At home form the	M 1 Yes 2 No			
\leq	I or Atten after deatl Director: I in by the	Certification;	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, streeth building, etc. (Specify)	eet, factory, office 2	8f. Location (Street : City or Town, Sta	and Number or Rura te)	al Route Number,
_	e Hospital or A 24 hours after E Funeral Dire etely filled in by	<u>S</u>	29a. Certifier Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, a	nd due to the cause	(E) and manner on a	totod
	T 4 F 0	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inv	restigation, in my opinion, death occurre	d at the time, date a	nd place, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month,	Day, Year)
			Mouse My Matter	02435)	8-	4-05	
)	+6	I	30. Name and address of person who completed cause of death (Item 23a) (Type, I	Plate mo	2064	6	
5ª	Sta	te	31. Date filed (Month, Day, Year) AUG 0 9 2005		0-0-0	O	
(E)	Registra	iř .	AUG 0 9 2005	asti)			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1 2. Date of Death Decedent's Name (First, Middle, Last, Yeer Physician Month 0200 N TLLEN 05 TOR TELD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Fecility Name (If not institution, give street and number) Examiner DALISBURU COMIC DME 0_ UASING NCHORAGE If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Min. Days Hours 1 🕱 M 2 🗆 F 230-52-5045 63 Yrs. Director Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or iteme 23a or 28e-f ehow traumatic event, the Modical Exactly ar must be inclined at 1 ☐ Yes 2 No Director MANTIC 100M100 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 230 85 VANTICOKE death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itel 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ If Yes, Give Year or Dates: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ABORER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ANNALAURA 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD, QUANTICO 21856 JOHNI KEID-BROTHER MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition tment of 1 D Buria 2 ☐ Cremation 3 ☐ Removal from State FREEMAN 30 Department Important: 0.5 * 4 □ Donetion | 5 □ Other (Specify) SMIT permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BENNIE any is SALISBURY MD 21801 SABELLA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CEVEBUO VASUIAV **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-transit and Due to (or as a consequence of). Box 68760. physician Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. ☐Yes 2☐No the detached 9□ Unknown 9 ☐ Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ SCUD 3 Probably 4 Unknown 1 Yes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed: 2 10 No certificate 2 No 1 Yes 1 Yes Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 11 Worsing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? After Medical Certification: 1 Natural 5 Pending 1 Yes 2 No death. investigation the f 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 7/22/05 Woondu D 22014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St 504 B Salisbury MB 21804 106 WILFOUD MAHESH WOONDRA 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 5 2005 Registrar

Physic		Registrar 1. Decedent's Name (First, Middle, I		partment of Health and I ertificate of Death	2. Date of Death	2005	26030 3. Time of Death
		David	H. Ra	nsom	July 2	20,2005	1410
/Med Exami		4a. Facility Name (If not institution, G	rive street and number)	4b. City, Town, or Location of Death Rockville		4c. County of Death Montgom	
Funeral Director		5. Social Security Number 237-20-1960 Usual Residence of Decedent	Sex 7. Age (In yrs. last birthda 1 X M 2 F 8 3 Yrs.	Months Days Hours Min	8. Date of Birth (Month, Day, Y		place (State or Fore
a-f show	ctor	10a. State 10b. County	nomery 10c. City, Town or Beth			1	0d. Inside City Lim
23a or 28 ast be no	Funeral Director	10e. Street and Number 6021 Kingsfor	d Road	10f. Zip Code 20817	10g	Citizen of What Cour	ntry?
natural', or Items 23a or 28a-f show dical Examiner must be netified at	þ	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ②Yes 2 □ No 1949 → If Yes, Give Year or Dates: 1951	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: W	
within ene. than "	Completed	15. Decedent's (Specify only highest statementary/Secondary (0-12)	Education 16a. De 16a. De (Grade completed) 16b. 16b.	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher MC			dustry
al Hyg Fother vent,	To Be Co	17. Father's Name (First, Middle, La Harrison Ran	st)		ne (First, Middle, Mai e Ella L	iden Sumame)	1
of Health and Ment fitam 27 te marked r other traumatic e		19a. Informant's Name/Relationship Anna V. Ransom		uiling Address (Street and Number or Ru 21 Kingsford Roa			
		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	20b. Place of Dis	position (Name of rematory or other place) peake Crem. 7/2	Date 200	c. Location - City or To	own, State
Department Importent: any injury conce.		21. Signatu e i Funeral Service di		PHILIP D.RINALD: 9241 Columbia B			
nysician Medical Me pruial-transit pe pruial-transit	ner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence of):	arcinomatosis dominal Leiomyos	sarcoma		
sician and e burial-trans	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of):				
y the attending pl ached for use as t	Ical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	B □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year
yy the attending pl ached for use as t	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c	5 ☐ Other (specify)	23e. Did tobac	Month	Day Year
ite has been signed by the attending pl page 2 should be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1	5 ☐ Other (specify)		Month co use contribute to the 2 No 3 □ Probe 24b. Were autor prior to correct to correct death?	Day Year le cause of death? ably 4 Unknotosy findings availant pletion of cause
ite has been signed by the attending ploage 2 should be detached for use as t	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions 25. Was case referred to medical examiner?	c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown contributing to death but not resulting in the	□ Other (specify) underlying cause given in Part I. 26. Place of Dea	1 Yes 24a. Was an autopsy performed 1 Yes 2 X	Month co use contribute to the 2 No 3 □ Probing 24b. Were autoprior to comprior to complete the thing 1 □ Yes	Day Year e cause of death? ably 4 Unknoon psy findings availa npletion of cause of
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tter death. Director: After this certificate has been signed by the attending pl In by the tuneral director, page 2 should be detached for use as t	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown contributing to death but not resulting in the 1 Inpatient 2 ER/Outpati 28a. Date of Injury (Month, Day Year) 28b. Time Injury 28b. Place of Injury - At home, farm, shoulding, etc. (Specify)	aunderlying cause given in Part I. 26. Place of Dea 27. Place of Dea 28. Injury at Work? M 1 Yes 2 No street, factory, office	1 Yes 24a. Was an autopsy performed to the Check only one) ome 5 Residence 28d. Describe how in the Check of the Check only one in the Check only one in the Check only or Town, S	Month co use contribute to the 2 No 3 Probing Prior to condeath? 1 No 1 Probing Prior to condeath? 1 In Yes	Day Year le cause of death? ably 4 Unkno
tter death. Director: After this certificate has been signed by the attending pl In by the tuneral director, page 2 should be detached for use as t	ledical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not 4 Homicide 1 Certifying F 29a. Certifier (Check only one)	c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown contributing to death but not resulting in the 1 Inpatient 2 ER/Outpati 28a. Date of Injury (Month, Day Year) 28b. Time Injury 28b. Place of Injury - At home, farm.	ath occurred at the time, date and place, investigation, in my opinion, death occurred to the result of the result	24a. Was an autopsy performed: 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how in 28f. Location (Stree City or Town, S) and due to the causined at the time, date	Month co use contribute to the 2 No 3 □ Probe 24b. Were autory prior to condeath? 1 □ Yes e 6 Nother (Specify injury occurred t and Number or Rural tate) e(s) and manner as stand place, and due to	Day Year le cause of death? ably 4 Unknot posy findings availa inpletion of cause of 2 No No No Route Number, ated. the cause(s)
death. ctor: After this certificate has been signed by the attending pl rthe tuneral director, page 2 should be detached for use as t	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1	C. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1	26. Place of Dea ent 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No street, factory, office ath occurred at the time, date and place, investigation, in my opinion, death occur 29c. License number	24a. Was an autopsy performed: 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how in 28f. Location (Stree City or Town, S) and due to the causined at the time, date	Month co use contribute to the 2 No 3 Probe 24b. Were autory prior to condeath? 11 Yes 6 Sother (Specify injury occurred	Day Year le cause of death? ably 4 Unkno posy findings availa inpletion of cause of 2 No No No Route Number, ated. the cause(s)

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	Physici		1. Decedent's Name (First, Middle	e, Last)	W ₁ LOO				2. Date of De Month July		y Year	3. Time of Death 3:56 P M
	/Medic		Rose Keperwas F		or)		4b. City, Town, o	or Location of Death			: County of Deat	
	Examir	ier	Suburban Hospit	_	,		Bethesda			Mo	ontgomer	y
	Funeral		5. Social Security Number	6. Sex 7	Age (In yrs.	last birthday,	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bi (Month, D	irth	9 Rin	hplace (State or Foreign untry)
	Director		577-62-1392 Usual Residence of Decedent	1 □ M 2 🔀 F	91	Yrs.		Tiours With	July 4		14 Mich	igan
	show	2	MD Montgo	Nm 0 7 W		y,TownorL Sethese						10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	r 28a-f	Director	10e Street and Number			Cenes	10f. Zip Code			10g. Ci	itizen of What Co	puntry?
	th wit		4925 Battery Le	Lane #70	13		2081	.4		Unit	ed State	s of Americ
36	72 hours after death with the Maryland Instural; or Items 23a or 28a-f show disal Examinat must be notified at	y Funerai	11. Marital Status 1 □ Never Married 2√2 Mare 3 □ Widowed 4 □ Divorced	If Yes Give	s? ⊋No	.S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: W	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I file importent: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating the Lodified at once.	Completed by	15. Deceden (Specify only highe	t's Education st grade completed)		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of world)	king	16b. k	Kind of Business/	Industry
72		m _o	Elementary/Secondary (0-12) 1 2	College (1-4	or 5+)	Home	maker			Own	n Home	
		Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nan	ne (First, Middle	e, Maidei	n Sumame)	
<u>lar</u>		To B	Benjamin Keperv	vas				Jennie	Rosen			
Maryland			19a. Informant's Name/Relations	thip (Type, Print)			,	t and Number or Ru				
≥			Bernard J. Rod	, Son	1			ss Hollow				
Baltimore,	Pages 1 ment of Hi lent: If iter		20a. Method of Disposition 1☆ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ile	lean M		ens July		5 01:		
3all	Separi Depari Mpor Iny in		21. Signature of Funeral Service									Home, Inc MD 20904
	/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	c Con as a conseq as a conseq as a conseq	uence of): uence of):	e Heart I	Failure				Onset and Death
. Box 68760,	ath certificate be attending physici for use as the bu	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	d	me of pregna n 2 ⊡ Feta t at time of d	ancy	⊒Ectopic pregnanc ⊒ Other (specify)	cy			23d. Date of de Month	livery Day Year
P.0	that the dended by the a	by Phy	9 Unknown Part II. Other significant conditi			ulting in the	underlying cause g	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ords	w requires been sign should be		Renal Failure						1]Yes 2	3 Pt	robably 4 Unknown
al Records,		Completed							per 1 ☐ Yes	opsy formed? 2 X N	prior to death?	utopsy findings available completion of cause of
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1√Z Inp	ationt 3	ER/Outpatre	nt 3□ DOA Ot	26. Place of Dea			6 ☐ Other (Spe	wifu)
of	ing After une		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of I		28b. Time Injury	of 28c. Inju		28d. Describe			Ciry)
Division	i de i	Certification;	3 Suicide 6 Could 4 Homicide determ	ninged 289. Place of	Injury - At h etc. (Specil	ome, farm, s fy)	treet, factory, office		28f. Location City or To			ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medicai (29a. Certifier 1 Certifyir (Check only one)	ng Physicien: To the be Exeminer: On the basi and manner	s of examina	owledge, dea ation and/or i	th occurred at the t nvestigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time	e cause(: e, date ar	s) and manner as nd place, and due	s stated. e to the cause(s)
	To the Within To the Comp	Me	29b. Signature and title of certifie	er	1		29c. Licen	se number			ate signed (Mont	
}	(1/1	ell	11/	0		6259		Ju1	y 22, 20	005
	,		30. Name and address of person Ava A. Kaufman	_		consin	Avenue S	Suite 103	Bethes	da M	D 20814	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year, JUL 2		istrar's Signa	ature	arti					

516	52		1- For Unpend Item Registrar	23a,27,28	aryland Dep	ndelible ink	Leath eas	Mental Hyg	Are Legible.				
98/		. 3	1. Decedent's Name (First, Middle, L.		CE	ertificate of	Death	2. Date of Deat		26032			
1	Physici		Michael Keith Ru	,				Month July 31	Day Year	3. Time of Death			
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100	· ·		8400 Wisconsin A	venue RM	#214	Betheso		Montgor					
É	Funeral		Social Security Number 6.		e (In yrs. last birthday		If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Bin	thplace (State or Foreign ountry)			
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	iand ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits			
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	th the	Director	10e. Street and Number	inc L y	DIIVEI E	10f. Zip Code		10	g. Citizen of What C	ountry?			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, I'm Medical Examinant required any injury or other treumatic event, I'm Medical Examinant required.		11 Schindler Ct			2090	3	Ţ	JSA				
	tems fr	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of I	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi				
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐X If Yes, Give Year or Dates:	No	1 Yes 2 No	Specity:	0.11	Specify:				
Maryland 21215-0036	2 hou		15. Decedent's 8	1	16a Dece	edent's Usual Occur	nation			White			
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2	filed wit Hygiene other the	E O	Clossically (5-12)	4		Numismat	ist		Collectio	ns			
ם	be file id oth	Be	17. Father's Name (First, Middle, Las.	1)			18. Mother's Nam	ne (First, Middle, M					
Уlа	should Ind Meni	၉	L. Leonard Ruben				Ida Ga						
Mar	12 sh h and 7 is m reum		19a. Informant's Name/Relationship						City or Town, State,	Zip Code)			
e,	1 and Health em 27 ther tr		Ida G. Ruben/Mot 20a. Method of Disposition	her					MD 20903				
2	Pages net: If It		1 Burial 2 ☐ Cremation 3		20b. Place of Disponentery, cre		1		Oc. Location - City or				
Baltimore,	artme orten injury		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice		_ Judean M			3, 2005	Olney, M	D			
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289	death certificate I e attending physi d for use as the b			d									
X Q Q	n certi nding use a	clan/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of del	P/OR/			
	0 0 2	cla	in the past 12 months?	4☐Pregnant at		Ectopic pregnancy Other (specify)	y 		Month	Day Year			
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r S	as t gne	by F	Part II. Other significant conditions of	contributing to death bu	ut not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did toba	icco use contribute to	the cause of death?			
cords,	w require been si should b	ted						1 Tes	2 □ No 3 □ Pr	obably 4 XUnknown			
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	i o the hours after deeping Physician: The law within 2 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier 1 Certifying Ph	ysician: To the best of	f my knowledge, deatl	n occurred at the tin	ne date and place	Clarlon	Hotel)				
,	the P	_ 1		niner: On the basis of and manner sta	ted.	vestigation, in my o	pinion, death occur	red at the time, dat	e and place, and due	to the cause(s)			
i	N N N	-	29b. Signature and title of certifier	4. 0	.4.	29c. License	e number	290	f. Date signed (Month	n, Day, Year)			
-	4	-	Jasteg	recel	WW.		м.е.	Au	gust 1, 20	005			
			30. Name and address of person who Tasha Z Gree	nbern M			Street D	altimoses	Maryland	21.201			
The same	Stat	e	31. Date filed (Month, Day, Year)	32 egistra	r's Signature	TI LEIIII	orreer, D	arthnore,	racytand	21201			
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			For State Registrar	State of M	larylan		artmen rtificat				Reg. No.	005	26033
	Physicia	an	Decedent's Name (First, Middle, La	ist)						2. Date of De		. 2005	3. Time'd Death
	/Medic	al	Dale Louis Rau)		4h City	Town ort	ocation of Deatl			County of Dear	
	Examin	er	4a. Facility Name (If not institution, given Saint Joseph	Medical	Cent	cen	40. 049,		Tows		"		imore
Ī	Funeral Director			Sex 7.A	ge (In yrs.	last birthday) Yrs.	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Da May 29			thplace (State or Foreign ountry) yland
T	ס		Usual Residence of Decedent				(acatina				-		10d. Inside City Limits
	show	5	10a. State 10b. County			y, Town or Lo							1 ☐ Yes 2 ☑ No
	the M	Director	Maryland Baltimo 10e. Street and Number	re	Bal	timore	10f. Zip	Code			10g. Citi	zen of What Co	
	3a or	Ö	8500 Cove Road				212	22			USA		
	deatl	Funerai	11. Marital Status	12. Was Decedent	2	.S. 13.			anic Origin? (S Mexican, Puert	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, Whit	
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ξ	within 72 hours after death with the Maryland ene. Than "natures", or items 23a or 28a-f show the Madical Examiner must be notified at	ed b	15. Decedent's E	ducation	8/09/		dent's Usua	I Occupati	on			nd of Business	
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ylan	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene at the file at 18 and	2	19a. Informant's Name/Relationship			19b. Mailir	na Address			iral Route Numb		r Town, State,	Zip Code)
=	and 2 seath an n 27 ls		Jeffrey W. Raub/				•	•		ve Oran			
ש	es 1 and 2 of Health f item 27 I		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3		20b. F	Place of Dispo	sition (Nar	ne of ther place)	Ju	Pate 26,		cation - City or	
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	permit, Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Lice	tomoth	MO1	251 B	ever1	y L.	Heckrot	on Serv te, P.A	. Cla	P.O. B	ox 784 1e, MD 21029
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90		edical		_ d									
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ם כ	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant a 9□Unknown			Other (sp					Month	Day Year
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DIVISION	after dea after dea Director	ertification;	3 Suicide 6 Could not 4 Homicide determine	200. Flace of I	njury - At h etc. <i>(Specil</i>	ome, farm, str	reet, factor	, office		28f. Location City or To			ural Route Number,
	To the Hospital or Attending Physicien: white 24 hours after death as a first death first certifies completely filled in by the funeral director, to	edical C	29a. Cartifier (Check only one) Certifying F	Physician: To the bes aminer: On the basis and manner s	of examina	owledge, deat ation and/or in	h occurred vestigation	at the time , in my opir	n, date and place nion, death occi	e, and due to the urred at the time	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier		0	W) 29	. License	number		29d. Dat	e signed (Mon	th, Day, Year)
			1 Kabad	L. Lwet	trici	, we	I	318	326		7-2	5-05	
1	4		30. Name and address of person who					of temper	And have as a trans-	min hard a foot hour o		0.0014 m.	Agric one or one one of
1	Sta	ato	RICHARD L. LII 31. Date filed (Month, Day, Year)		M. D.		or US)LEK	DKIVE	TUMSU	ч <u>, г</u> л	HKYLHN	ID 21204
	Registr		Mt 27	2005	25	4							

DHMH 17 Rev 1/2001

ROTTMAN 1/26/05

DOLORES

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death Month 1, Decedent's Name (First, Middle, Last) Day **Physician** Nelson Rov Ruark 2005 7:00 p July 22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Dorchester 202 Glen Oak Circle Hurlock If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 10, 1927 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Days Hours Maryland 10 M 2□ F 78 Director 213-22-5141 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County or then "naturel", or Items 23a or 28e-f ehow the Medical Examiner must be notified at 1 XYes 2 □ No Hurlock Director MD Dorchester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21643 202 Glen Oak Circle death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 □ Never Married 2 □ Married Saltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 □ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 tont of Health and Mental Hygiene. Int: If item 27 is marked other then "nati College (1-4or 5+) Elementary/Secondary (0-12) painter construction treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Spedden Roscoe R. Ruark ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8335 Taran Court, Easton, MD Deborah Timms daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 7/25/05 Salisbury Crematory Salisbury, MD `4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signatur of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardiel minuls **Physician** /Medical Due to (or as a consequence of): Examiner 1abeles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Hype Cension Due to (or as a consequence of): the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760. the death certificate be Physician/Medical JF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown sate has been signed by a page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perfor 2**X** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death the Hospitel or Attending Find 24 hours after death. 1 KNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a, Certifie 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Phy Siccas Do052255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cambridge 110 2/6/3 Lesa Peake Bay Dr. EJas 140 830 32. Register's Signature 31. Date filed (Month, Day, Year) State Registrar

			State of Maryland / Department	artment of Health and M <i>rtificate of Death</i>	lental Hygiei .Reg.	2005	26036				
			Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death				
	Physici /Medic		William Rountree Sr.			5 2005	7:30a [™]				
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
			Manor Care Nursing Home	Bethesda If Under 1 Year If Under 24 Hrs.	O. Date of Birth	Montgome	ry				
45°	Funeral		5. Social Security Number 6. Sex 1 🖾 M 2 🗆 F 84 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Cour					
	Director	1	577-24-2343 84 Usual Residence of Decedent		APFIL 17	, 1921 500	th Carolina				
	/land		10a. State 10b. County 10c. City, Town or Lo	ocation		1	0d. Inside City Limits				
	Man	tor	Maryland Montgomery Silver S	Spring			1 Yes 2 □ No				
	th the	lrec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?				
	th wil	a D	9805 East Light Drive	20903		USA					
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event. The Modified Examination traumatic event.	ed by Funeral Director	1 Never Married 2X Married 3 Widowed 4 Divorced 1X Yes, Give -1/17/1946	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify: dent's Usual Occupation		14. Race - Americ Black, White, Specify: B1 b. Kind of Business/In	etc. .ack				
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m	Menta Senta rked rlc ev	To B	Joseph Rountree	Maude D	avis						
Maryland	should have		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rur	al Route Number, Ci	ty or Town, State, Zip	Code)				
	and 2 salth n 27 i			East Light Drive,			20903				
altimore,	of He		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State	osition (Name of matory or other place)	Date 200	. Location - City or To	own, State				
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Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	² Name and Address of Facility Fort Lincoln Funer 18401 Bladensburg R	al Home d., Brenty	vood MD	20722				
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Reć	The lay cate has	ш	(000-		autopsy performed	prior to co death?	impletion of cause of				
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Divis	or Attendated after death	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Run tate)	al Route Number,				
	To the Hospital or Attenwithin 24 hours after dealt To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 1 Medical Examiner: On the basis of examination and/or in and manner stated.								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month,					
)			+ transas Mo.	1253691		July. 2	5-2004.				
R	-(3) IVG		30. Name and address of serson who completed cause of death (Item 23a) (Type	Print) Democracy Blvd	Beine	sda, I mo	5.2004.				
	Sta Registi		31. Date filed (Month, Day, Year) 1111 2 6 2005	di)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amended item #26 per dr/wichartificate of Death 7-25-05/dls Reg. No. 005 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Yaar **Physician** 2005 0555 20 Comie Scott /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 544/5611 Niamic ENINSULA 210NA 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Social Security Number 6 Sax **Funeral** Min. Months Days 1**⊠**M 2□F 76 SC Director 262-40-4225 Mar 1. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County show ral, or Itams 23a or 28a-f shov Examinat must be notified at Yes 2 No Director Eden MD Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. 21822 4754 Upper Ferry Rd. by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic avant, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than 2 should be filed within and Mental Hygiene. Concrete Self employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be markad Maebell Peoples Isom Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30900 Ward Rd., Salisbury, MD 21804 Evangela Duffy/daughter othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any injury or o Department of 1 Surial 2 Cremation 3 Removal from State Green Acres Mem Park 7/23/2005 Salisbury, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Lewis N. Watson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. MD Approximate Interval Between Onset and Death Immediate Cause (Final a Physician disease or condition resulting in death) /Medical s a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine g physician and as the burial-transit post a 001 0 Due to (of as a consequence of): Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? for 4 Pregnant at time of death 5 Other (specify) the 9 Unknown څ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2□ No certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 Inpatient Other: 4 A Aursing Home 5 Residence 6 Other (Specify) 2 RVOutpatient 3 DOA 2 2 No 1 Yes Division of this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred After t Certification: the Hospital or Attending 1 Matural 5 Pending investigation 1 Yes 2 No death. 2 Accident Diractor: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

William

31. Date liled (Month, Day, Year)

Carroll

fistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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JUL 2 5 2005

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Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month July Σay 2Ι, 2005 **Physician** 11:55P M SALL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery 9216 Bells Mill Road Potomac If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 24, 1941 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours 1₩ 2□F Pennsylvania Yrs 63 Director 201-30-8327 Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Counts ral', or Itams 23a or 28a-f ehow Exertiner must be nutified at 1 ☐ Yes 2 No Director Potomac Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20854 United States of America 9216 Bells Mill Road filed within 72 hours after death Hygiene. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give 1962-63 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic evant, the Mudical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 Is markad othar than "r Elementary/Secondary (0-12) College (1-4or 5+) Finance Executive Recruiter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Paul Isadore Sall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9216 Bells Mill Road, Potomac, MD 20854 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sinent of Health an Susan A. Sall - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition Cremation 3 Removal from State Garden of Remembrance permit. Pages Department of Important: If it any injury or o 1 ☑ Burial 07/24/05 Clarksburg, Maryland ¹ 4 □Donatj6n 21. Signature of Funeral Service Licens Edward Sage I Funeral Direction, Inc. 1091 Rockville Pike, Rockville, MD 20852 ð 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. list only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Follicular Thyroid Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to for as a consequence of Examiner or Attanding Physician: The law requires that the death certificate be executed as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Malignant Cervical Spinal Cord Compression 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 X No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 Tes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 □Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To tha Funaral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 22, 2005 D41218 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1335 Piccard Drive, Rockville, MD 20852 Charle Michael Harrison, MD Fegistrar's Signature 31. Date filed (Month, Day, Year) 32 State JUL 2 6 2005 Registrar BULL

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. () 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 7:00 P AUG 2 2005 BERTHA ELLEN SNYDER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FROSTBURG ALLEGANY 175 DEPOT ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Months 1□M 2 F Yrs 95 SEPT 21 1909 MARYLAND Director 220 46 8134 Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a, State 10h Counts 28a-f show or then "neturel", or Items 23s or 28a-f show the Medical Examinar must be nutified at 1 ☐ Yes X☐ No Director MARYLAND ALLEGANY FROSTBURG 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 175 DEPOT ROAD 21532 U.S. within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "n College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be OLEN WINEBRENNER GRACE B. STEVEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is ROSE MARY SNYDER / DAUGHTER 175 DEPOT ROAD, FROSTBURG, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ urial 2 ☐ Cremation 3 ☐ Removal from State ST. MICHAEL'S CEM. FROSTBURG, MD 8/5/05 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 60 W. MAIN STREET any is SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 11601 Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to infinitely acuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed Due to (or as a consequence of): burial physician Physician/Medical the attending p IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. the 9 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 1 ☐ Yes 2 ☐ No certificate 2X No 1 ☐ Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 29 Other: 4 Nursing Home Hesidence 6 Other (Specify) 2 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28d. escribe how injury occurred Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Hospital or Attending 5 Pending investigation 1 Accident death. 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 - Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License numbe 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT E. RAPP, M.D., 912 SETON DRIVE, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

			1 - State Registrar Amend Item	State of Marylan per FH, C847	d / Depa ,09/<u></u>}ሪ	artment o	f Health an of Death	nd Mental Hy	rgiene Reg. 1 2 .	005	26041
		'an'	1. Decedent's Name (First, Middle, Last)					2. Date of Do Month	eath Day	Year	3. Time of Death
	Physici /Medic		Thelma Daly Sl	naffer				Ju1y	17	2005	4:36 P _M
	Examin		4a. Facility Name (If not institution, give s				n, or Location of [Death		County of Dea	
			4701 Willard Avenu		In me brinebala	Chevy (Hrs. 8. Date of Bi		ntgome	thplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Security Number 1	7. Age (In yrs. 87				Min. (Month, D	ay, Year)	_ C	sh. D.C.
			Usual Residence of Decedent	- 07		l		DCC 10,	, 171	/ NGS	
	ryland how		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Sa-f s	cto	MD Montgomer	y Che	vy Cha					· · · · · · · ·	1 ⊠ Yes 2 □ No
	or 28	Director	10e. Street and Number	"006		10f. Zip Cod				zen of What C	
	s 23a	rai	4701 Willard Avenu	e #926 12. Was Decedent Ever in U	C 12		0815	2 (Specify Yes or N		ed Stat	
36	be filed within 72 hours after death with the Maryland tal Hygiena. id other than "natural", or Itams 23a or 28a-f show evant, the Madical Examine that the mailined at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑		n? (Specify Yes or N Puerto Rican, etc.)		Black, Whi	te, etc.
21215-0036	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Oc	ccupation	funding	16b. Kir	nd of Business	s/Industry
215	- 1	Completed	(Specify only highest grade	College (1-4or 5+)	life.	DO NOT use re	one during most o atired)	r working	Dep	artment	t of
	filad withii Hygiena. othar than ant, Itte M	Con		2	Secre	tary			Defe		JS Fed. Gov
Maryland	should be filad withir and Mantal Hygiena. marked othar than matic evant, the M	a)	17. Father's Name (First, Middle, Last)					Name (First, Middle Downs	э, маюел	Sumame)	
Z	2 should be to and Mantal is marked or raumatic eva	To	Daniel Daly	no Rojat)	10b Maili	na Address (St		or Rural Route Numb	her City or	Town State	Zin Code)
Ma	d 2 sl th an T Is r traur		19a. Informant's Name/Relationship (Ty			-		gham, Mass			
	t Health Itam 27 other tre		Kyle Shaffer / Dau 20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of	f place) Ti	1y 30,	20c. Lo	cation - City o	r Town, State
9	Page:		1 ☐ Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ort Cre		2005	Alex	andria	, Virginia
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Manta Important: If Itam 27 Is marked any injury or other traumatic events.		21. Signature of Funeral Service License	Bugge				Joseph Gaw ve. NW Was			
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat	h. Do not en	ter the mode of	dying, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
M	Physician		Immediate Cause (Final disease or condition	Cardiac Arı	cest						Onset and Death Minutes
	/Medical Examiner		resulting in death)	Due to (or as a conseq							
١.	LAGITITIES	_	Sequentially list conditions, if any, leading to immediate	Atheroscler Due to (or as a conseq		Coronar	y Artery	Disease			Months
	lad	niner	cause. Enter Underlying Cause (Disease or injury	Hypertensio							
	be exacutad sician and buriat-transit	Examin	that initiated events resulting in death) Last	Due to (or as a conseq							
8760,	ate be hysiciar the buri	dicai	Ų,	Dyslipidemi	La						
9	tificate ng phys as the	ledi									
S. Box	The law requires that the death certificate be exacuted to has been signed by the attending physician and to asset 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 Live birth 2 □ Feta 4 □ Pregnant at time of degree Unknown	Ideath 3	Ectopic pregn Other (specif			2	23d. Date of de Month	elivery Day Year
P.0	that the		Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	inderlying caus	e given in Part I.	23e. Did	tobacco u	se contribute l	to the cause of death?
rds,	w requires the bean signad should ba de	ed by						1 🗆	Yes 2	No 3∏F	Probably 4X Unknown
of Vital Records,	The law re ate has be page 2 sho	Completed						24a. Wha auto peri 1 □ Yes	s an opsy formed?	prior to death?	utopsy findings available completion of cause of
ta	10 T	O	25. Was case referred to medical				26. Place o	f Death (Check only			
\	Physician: this certific ral director,	To B	examiner? 1 AYes 2 No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA	Other: 4 Nurs	ing Home 5 X Res	sidence 6	6 ☐Other (Sp	ecify)
0			27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		Injury at Work?	28d. Describe	how injury	y occurred	
Sio	ten leat tor: the	cati	2 Accident investigation 3 Suicide 6 Could not be	20a Place of Injury At h	ome form of	M soat factors of	1 ☐ Yes 2 ☐ No		(Street and	d Number or F	Rural Route Number,
Division	al or Attendes safter death	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	fy)	reet, factory, or	lice		wn, State)		in a riodio riamoor,
	To the Hospital or At within 24 hours after of To tha Funaral Diracl completely fillad in by	edical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owiedge, deal	th occurred at the overtigation, in	ne time, date and my opinion, death	place, and due to the occurred at the time	e cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Ba		29c. Li	cense number		29d. Date	e signed (Mor	nth, Day, Year)
)	12		100	100m		405	576 – MD		July	18, 20	005
	5		30. Name and address of person who co								
			Ramin Oskoui MD 3	301 N. Mexico	Ave.	NW #316	. Washing	gton DC 20	016		
	Sta Registi		31. Date filed (Month, Day, Year)	3 Registrar's Signa	The Ago	even					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25^{Day} Physician July 2005 1:25 MICHAEL SEKELLICK A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 12,1942 Birthplace (State or Foreign Country)
 PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1XM 2□F June 168-34-4140 63 **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "netural", or Itams 23a or 28e-f show other treumatic event, the Medical Exact ratifical at 1 ☐ Yes 2X No Director Md. Montgomery Clarksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26217 Rudale Drive 20871 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status withIn 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) U.S. Department of Elementary/Secondary (0-12) Engineer 5+ the Navy permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Kozura John Sekellick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clarksburg, Md. 20871 Therese Sekellick (Wife) 26217 Rudale Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition any injury or c July 27, 2005 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, 20877 Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a co sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dual to (or us a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy ō in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the ald be detached for ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 🗆 No 3 Probably 4c HIKNOWN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed certificate 2 🗆 No 1 Yes 1 Yes 2 No To the Hospitel or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 00 cur) 30. Name and address of person who completed cause of de th (Item 23a) (Type, Print) Dr. Robert L. Gold M.D. 15225 Shady Grove Rd. #201 Rockville, Md. 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar JUL 26 2005

			For State	State of M		Department of Certificate of			0000	06010
			Registrar 1. Decedent's Name (First, Mic	Idle Lasti		Certificate of	Dealli	2. Date of Dea	Reg. No.	3. Time of Death
	Physici	an	SOL (MON	SII	VER		Month July 2	22, 2005 Ye	10:10 Am
	/Medic Examir		4a. Facility Name (If not institu	tion, give street and number,)	4b. City, Town,	or Location of Death		4c. County of D	Peath
	LXaIIII	iei	Manor Care - P	otomac		Po	tomac		Montg	omery
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birt	Months Davs		8. Date of Birt (Month, Da	th y, Year) 9.	Birthplace (State or Foreign Country)
	Director		165-03-2779	1 🔀 M 2□ F	90	Yrs.		Nov 16,	1914 P	ennsylvania
	and *		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City, Town	n or Location				10d. Inside City Limits
	/anyli	ъ	Maryland Mont	COMO EN	Rockvi	1116				1 X Yes 2 □ No
	the 286-	Pect	Maryland Mont	gomery	ROCKVI	10f. Zip Code			10g. Citizen of What	Country?
	3e or	0	14401 Traville	Garden Circl	e, #411	208	50		United	States
	72 hours after death with the Maryland natural', or Items 23e or 28e-f show disal Exam her must be inclified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp	pecify Yes or No-	- 14. Race - A	merican Indian, Vhite, etc.
9	or Ite		1 ☐ Never Married 2X N	larried 1 Tes 2X		1 ☐ Yes 2X☐ No		7 110011, 010.7	Specify	
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d 21	Hygi Hygi Sther ent, t	S	17. Father's Name (First, Midd	lle, Last)			7		Maiden Sumame)	
<u>a</u> n	id be lental ked c	To Be	Abraham S	ilver			Fan	nie	Go1d	berg
Maryland	shou and N s mai		19a. Informant's Name/Relation	onship (Type, Print)		Mailing Address (Stree			-	
	and 2 saith a n 27 i		Mark A. Goldbe	rg, Son-in-La		513 Snapdra				
ore	L SE E E		20a. Method of Disposition	on 3 Demoval from State	20b. Place of cemeter	Disposition (Name of y, crematory or other pla	ace)	Date	20c. Location - City	or Town, State
ij	Pag ment iuny		`4 □ Doylation 5 □ Other	(Spagey)	Judear	n Memorial				Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyghene. Importment of Health and Mental Hyghene. Importents: If Item 27 is marked other then "natural", or Items 23e or 28e-1 show any injury or other treumatic event, the Medical Example and once.		21. Signature of Funeral Servi	ce Likensee		22, Name and Addr Edward Sa 1091 Rock	ress of Facility gel Funer: ville Pik	al Direc e, Rockv	ction, Inc	20852
			23a. Part 1. Enter the disease	or complications that cause st only one cause on each	d the death. Do n					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		De	1000	ta			Onset and Death
	/Medical		resulting in death)	Due to (or as	s a consequence o	of):	CT LOC			1/3
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Вох	leath certifi attending p	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Petal death	3 □Ectopic pregnan	CV		23d. Date of	
	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use	Physician/M	in the past 12 months? 1 Yes 2 No		at time of death	5 ☐ Other (specify)	-1		Month	Day Year
P.O.	at the	Phy	9 Unknown		L. A A	the mederation comes	won in Part I	23a Did to	obacco use contribut	e to the cause of death?
	res th signed	by	Part II. Other significant cond	attons contributing to death	but not resulting in	i the underlying cause g	iven in Fait i.			Probably 4 Munknown
of Vital Records,	requ	Completed								autopsy findings available
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Ξ	sicie certi irecto	o Be	25. Was case referred to med examiner? 1 Yes 2 No	Hospital:	ient 2 ER/Out	tpatient 3 DOA	thor	ith (Check only o	dence 6 Other (Specify)
of	Attending Physicien: r death. ector: After this certific: by the funeral director, I	n: To	27. Manner of Death	28a. Date of Ini	ury 28b. T	Time of 28c. Inju			how injury occurred	
ion	utending death. ctor: Afte	atlo	1 KNatural 5 ☐ Per 2 ☐ Accident inve	nding (Month, D. estigation	ay rear) ir	, ,	Yes 2 □ No			
Division	r Atte	Certification:			njury - At home, fai	rm, street, factory, office	3	28f. Location (S City or Tox		r Rural Route Number,
	rs aft ral Di									
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 🔁 Certii (Check only 2 🗆 Media	fying Physician: To the bes cal Examiner: On the basis and manner s	of examination and	d/or investigation, in my	opinion, death occu	rred at the time,	date and place, and	due to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of cen	ifier		29c. Licer	nse number		29d. Date signed (M	lonth, Day, Year)
	D		1	Kauns		D3	1792		JULY,	12,2005
	(0		30. Name and address of per-	on who completed cause of	death (Item 23a) ((Type, Print)	101/07	00/7/	2 800	KULLENS
			2MHK00	L. M. KYOO	,00,	MIEDI	10/07 (DIO DI	7,700	1000,100
	Sta Regista		31. Date filed (Month, Day, Ye	///	trar's Signature	Sparke				CVILLE, M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Rag. No. () 2. Date of Death Decedent's Name (First, Middle, Last) Month 11:27 AM **Physician** 18 ames /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner River Chestertown Kent Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Rockhal Director MD Kent 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code ò USA or items 23e Completed by Funeral 12. Was Decedent By Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 and 2 should be filed within 72 hours after of tealth and Mental Hygiena. The street of the then "neturel", or flei 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: If Yes, Give Year or Dates: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worker Disabled 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LUKNOWN ARRIG livia 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2146/ 19a. Informant's Name/Relationship (Type, Print) Rockhall MD Department of Health a Important: If item 27 Is any injury or other tra Brown Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Route 298, Worton, MD FH, ammie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 3 day 22 /Medical Due to (res) consequence of): enlinour Examiner r as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of) attending physician Box 68760 Physician/Medical as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Œ. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed umeron Divertices 2 🗆 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Hospital: 1 ☐ Inpatient 2 PER/Outpatient 2 1 ☐ Yes 2 No 3□ DQA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After t 5 Pending investigation 1 Natural 2 | No within 24 hours after death. To the Funeral Director: A 1 Tyes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)21313

Registrar

DHMH 17 Rev 1/2001

State

. Chestartown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 2 5 2005 >

415 Washing 32. Regis as Signature

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31. Date filed (Month, Day, Year)

			1 - For State of Maryland / Dep	artment of Health and N		ene - 2005 26045
	1	<i>i</i>	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
ĸ.	Physicia /Medic		Elizabeth Lotito Scala		July 24	2005 11:50A ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Eumana!		4406 Ridge Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Chevy Chase If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birthplace (State or Foreign Country)
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	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
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	r 28a	Director	Maryland Montgomery Chevy Cha	10f. Zip Code	10g	J. Citizen of What Country?
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	er des Items	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
39	ar, or		1 □ Never Married 2 □ Married 1 □ Yes 2 ② No If Yes, Give 3 ③ Wildowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 📉 No Specify:		Specify: White
<u>ٻ</u>	within 72 hours after death with the Maryland ene. than "natural", or Items 23c or 28a-f ahow ha Medical Examinar must be notified at	Completed by	(Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of work		b. Kind of Business/Industry
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an	fental fental rked c	To Be	Antonio Lotito	Apolloni	ia Polino	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23c or 28a-1 ahow any injury or other traumatic event. The Medical Examinat must be notified at one.	-	, , , , ,	ing Address (Street and Number or Run		
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nor	ages int of h t: If ite y or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	ematory`or other place) [Ju]	ly 26,	denton, Maryland
altimore,	mit. Partme		21 Signature of Funeral Service Licenses	2 Name and Address of Facility		
m	Per Per Per Per Per Per Per Per Per Per		Beverly & Haltha MO1251 E	everly L. Heckrott	e, P.A. (P.O. Box 784 Clarksville, MD 21029
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arrest	t, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Adult Failure to	Thrive		5.105(4.10 504.1)
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	that the death certific ed by the attending p detached for use as	Physician/Me		Other (specify)		Month Day Year
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Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	Others	th (Check only one)	
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occur	rred at the time, date	a and place, and due to the cause(s)
	To the within 2 To the comple	ĕ	29b. Signature and tithe or certifies	29c. License number	29d	I. Date signed (Month, Oay, Year)
			CHILLI V	- 104121	8	4126105
VIC	20		30. Name and address of person who completed cause of death (Item 23a) (Type		- MD 200	055
	Sta	te	Charles Harrison M.D. 6001 Muncaster 31. Date filed (Month, Day, Year) 32. Signature		<u>.e, MD 208</u>	כני
	Registr		JUL 2 7 2005	Snorth o		

		1	For State Registrar	State of N	Maryland / Dep Ce		of Health a		Hygie Reg.	0000	,	2601.6
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	hysicia Medic/		Woodrow Ralph	Smith				Ju		24 20		8:10P M
	Examin		4a. Facility Name (If not institution			, ,	wn, or Location			4c. County of I		
			Harford Memo 5. Social Security Number		al Age (In yrs. last birthday)	Havr	e de Gr	24 Hrs. 8. Date	of Birth	Harf		ace (State or Foreign
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P			Usual Residence of Decedent		I to a city Town and						1/	Od. Inside City Limits
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1215-0036 within 72 hours after death with the Maryland ene,	ed other than "natural", or items 23a or 28a-f ahow event, the Medical Examinar must be rutified at	Funeral Director	466 Paradise	Road			21001		1 -	United		-
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60 01 00	27 ia r trau		Edna D. Smi					d, Aberde		-		
ore, M	item othe		20a. Method of Disposition		20b. Place of Disp		of proface)	Date	-	c. Location · Cit		wn, State
Page Thent	ant: if ury or		1 ☐ Burial 2 ☑ Cremation 1 ☐ Donation 5 ☐ Other (S	ipecify)	Mayerda]	e Crema	atory	July 26, 2004	N	ewark, 1	Dela	aware
Baltimore, permit. Pages 1 a Department of Hea	Important: if ite any injury or of ODCS.		21. Signature of Funeral Service	Censee			Address of Facil Funeral	12/	Soutl th Eas	h Main : st, MD	Stre 219	
100			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that causonly one cause on each	sed the death. Do not en h line.	ter the mode o	of dying, such as	s cardiac or respira	atory arrest	,		Approximate Interval Between Onset and Death
	sician		Immediate Cause (Final disease or condition resulting in death)		BROVASCUL	AR AC	CIDEN	τ				
	edical miner			Due to (or	as a consequence of):							
		Jer	Sequentially list conditions, it any, leading to immediate	b. Due to for	as a consequence of):		-					
Cuted	ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
50,	hysician and the burial-transit		resulting in death) Last	Due to (or	as a consequence of):							
Box 68760,	physic s the b	edical		d								
oertific	attending pl	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date o	f delive	ry
Box	d for u	Physician/M	in the past 12 months?	4□Pregnan	t at time of death 5	□Ectopic preg □ Other (speci				Month		Day Year
P.O	ed by the detached	hys	9 🗆 Unknown	9□ Unknow								(1, 1)
	be	ξ	Part II. Other significant conditi	· ·							ite to th □ Proba	e cause of death? ably 4 ②Unknown
Records,	s peen s	Completed	CORONARY	·	DISEASE	HYPEN	RENSIA	100	a. Was an			osy findings available
I Rec	has ye 2	mpl	HEPATITIS-	C					autopsy performe	d? prio	r to con th?	npletion of cause of
	certificate rector, pag	e Co	25. Was case referred to medica	1			26 Plac	1 □ se of Death (Check	Yes 2	No 1 L	Yes	2□ No
of Vita Physician:	S ip	O B	examiner? 1 ☐ Yes 2 No	Hospital:	eatient 2 ER/Outpatie	ent 3 DOA	Othor	lursing Home 5		e 6 Other	(Specify	')
	After th funeral	n: T	27. Manner of Death 1 Natural 5 Pendin	28a. Date of (Month,	Injury 28b. Time Injury	of 28c	. Injury at Work?	28d. Des	scribe how	injury occurred		
Vision Attending	tor: A the fu	catle	2 Accident investi	igation		М	1 Yes 2		-tine (C4	and Advantage	a. D	(Courte Alverter
5 p #	0 0	Certification;	4 Homicide determ	nined 286. Place of	Injury · At home, farm, s , etc. (Specify)	treet, factory, o	office		or Town,		or mura	l Route Number,
Hospital	e Funerai letely filled		29a. Certifier Certifyii	ng Physician: To the b	est of my knowledge, dea	th occurred at	the time, date a	ind place, and due	to the caus	se(s) and mann	er as st	ated.
16 HO3	To the Funeral Dir completely filled in	edical			is of examination and/or i							
To th withir	To the complet	Me	29b. Signature and title of certifie	112.6			icense number			. Date signed (/		
,	1		> Ku	Muspen		D	45344	/		07/25	/2c	05
4	DU L		30. Name and a less of person	0		, Print)	440	MANDE	200	2465	Mλ	1078
	Sta	ite	SURESH DIAA 31. Date filed (Month, Day, Year	NJANI MI	gistrar's Signature	WION	Note,	MYVKK	DIC 41	KHUE ,	10	21010
	Regist		JUL 2 6 20	105 Bleek	gistrar's Signature	a de la companya de l						

SMITH, WOODPON

		1 - For Amend Item: 5 1. Decedent's Name (First, Middle, Last		nd / Depa -847 26	artment	of H	ealth ar Death			ne N2005	26048
Physic /Med		MYRTLE BEATRI	'					l A		Day Year	3. Time of Death 5:55PM
Exam	ner	4a. Fecility Name (If not institution, give Collingswood Nurs	and the second		Rock	cvil				4c. County of Dee Montgome	ry
Funera Directo		5. Social Security Number 6. Se 243-12-9491 15	7. Age (In yr.	s. last birthday) Yrs.	If Under Months	1 Year Days	Hours	Min. (A	Pate of Birth Month, Day, Ye /18/192	ear) 9. Bis 21 Nort	thplece (Stete or Fore ountry) h Carolina
Maryland -f ahow	tor	10a. State 10b. County MD Montgomer		ckville	ocation			,			10d. Inside City Limi
h with the 3a or 28s	al Director	10e. Street and Number 913 Gabel Street			10f. Zip (10g. US	Citizen of What C	ountry?
ING 21215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. d other than "natural", or items 23a or 28s-f ahow event, the Mexical Exercit without the redified at	by Funeral	11. Maritat Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No tf Yes, Give Year or Dates:		Was Decedent Yes, special	fy Cubar	spanic Origin , Mexican, F Specify:	n? (Specify) Puerto Ricar	Yes or No- n, etc.)	14. Race - Am Black, Whi	te, etc.
d 21215-0036 filed within 72 hours all Hygiene other then "natural", or ent, the Medical Execution.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual kind of work DO NOT use Te116	k done di e retired)	tion uring most o	f working		Kind of Business	,
Maryland 2 Id 2 should be filled Ith and Mental Hygis It is marked other traumatic event, III	To Be C	17. Father's Name (First, Middle, Last) Jacob A. Bost]	Dora J	. Nasl		·	-
		19a. Informant's Name/Relationship (Ty Maurice D. Morriso								ity or Town, State, MD 20854	Zip Code)
0 0		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State	Place of Dispo cemetery, cres dar Hill	natory or oth	her place	´ I	Date /25/200		Location - City or	Town, State
Baltim permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens Many Hedgman		22	. Name and	Address	of Facility	Cedar		neral Ĥome,	Inc.
Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the declered cause on each line.	NAVO	er the mode			rdiac or resp なででな			Approximate Interval Between Onset and Death
box bb/bu, death certificate be executed a ettending physician and dior use as the burial-transit	ical Examiner	Sequentially list conditions, a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		quence of):							
that the death certificated by the attending price detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pre					23d. Date of del Month	ivery Day Year
law requires that as been signed by 2 should be deta	by	Part tl. Other significant conditions cor	itributing to death but not re	sulting in the ur	nderlying ca	use giver	n in Part t.	2	3e. Did tobacc		the cause of death?
The The te had age	Completed							_	4a. Was an autopsy performed	? prior to death?	itopsy findings availab completion of cause of
off Of Vital range of the confiction of the conf	tion: To Be	27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	_	Other c. Injury a Work?	4 Nursin	ng Home 5	ock on one Residence Describe how in	6 □Other (Specially)	city)
or Atter or Atter or Atter or Atter or Atter or Dy the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, stre			33 2 110	28f. Lc	ocation (Street lity or Town, St	and Number or Ru ate)	ıral Route Number,
the Hospital thin 24 hours a the Funeral t	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at restigation, in	t the time n my opii	, date and p nion, death o	lace, and du occurred at t	ue to the cause the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
To the within 2 To the comple	M	29b. Signature and title of cartifier				License	number	-80		Date signed (Monti	
e (12)		30. Name and address of person who and Seryed ElSayyad, M.D.	mp the cause of death (the 9715 Medical Ca	m 23a) (Type, I	Print)					, ,	
St Regist	ate rar	31. Date filed (Month, Day, Year)	3 Registrar's Sign			- + +	2 س و				

			Please	Type or Print in Black if		-	•
			For State		partment of Health and M		
			Registrar		ertificate of Death		2005 26049
	Physici	an	Decedent's Name (First, Middle, Last	-		2. Date of Death Month	Oay Year 3. Time of Death
	/Medic		LEVIN K.	IURNER	Tu Ch Tu		21 2005 1223 M
4	Examin	er	4a. Facility Name (If not institution, give Peninsula Regional M		4b. City, Town, or Location of Death Salisbury		Wiconico
	-		5. Social Security Number 6. Se	edical Center 7. Age (In yrs. last birthda)	The second secon	8. Date of Birth (Month, Day, Yea	
	Funeral Director			M 2 F 9 Yrs.	Months Days Hours Min.	(Month, Day, Yea	Country) MD
	ס		Usual Residence of Decedent				
	rylan how		10a. State 10b. County	10c. City, Town or I	Location		10d. Inside City Limits
	Ba-f a	cto	MO SOME	ASET PRINC			1 ☐ Yes 2 No
	ith th	Dire	10e. Street and Number	7	10f. Zip Code	10g. (Citizen of What Country?
	72 hours after death with the Maryland matural', or Itame 23a or 28a-f ehow dical Examinational behalitied at	Funeral Director	28780-LARRY L	ANKFORD KD	21853		USA 14 Page American Indian
	er de Itam	nne	11. Marital Status		. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: BLACK
21215-0036	"natural",	ed	15. Decedent's Edu		edent's Usual Occupation	16b.	Kind of Business/Industry
215	C	ple	(Specify only highest grad	de completed) (Giv life.	edent's Usual Occupation re kind of work done during most of worki DO NOT use retired)	ng	
21	d with	Completed	7	W,	ATERMAN	5	ELF-EMPLOYED
pu	al Hygi I othar vant, I	Be (17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maid	en Sumame)
<u>a</u>	2 should be filed withir and Mental Hygiene. ie marked other than aumatic evant, the M.	10	ROBERT T	URNER	SIDNE	Y NUTT	ER IVRNER
Maryland	2 shc and ie mu	14	19a. Informant's Name/Relationship (T)		iling Address (Street and Number or Rura	Route Number, City	or Town, State, Zip Code)
	s 1 and 3 of Health itam 27 other tr		MARY L. IURNER-	WIFE 287	92-LARRY LANKFORD KI		HANE 111 D 41823
or	ges it of h		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	ematory or other place)	200.	Location - City or Town, State
Baltimore,	nit. Pages 1 and 2 should be filed withl artment of Health and Mental Hygiene. ortant: If item 27 ie marked other than injury or other traumatic evant, Illia M. 9.		`4 □Donation 5 □ Other (Specify)	10.00	CHURCH CEM! 7/2	7/05-063	STERVILLE IVID
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	Parada	22. Name and Address of Facility	NNIE	DMITH FIH
			23a Part 1 Enter the disease or comp	lications that caused the death. Do not e			Approximate
			shock, or heart failure. List only o Immediate Cause (Final	one cause on each line.		, , , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a. <u>metastatic</u> Due to (or as a consequence of):	prostate Cancer		5 years
	Examiner						
20		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
	te be executed ysician and e burial-transit	Examiner	that initiated events	c			
760,	be execut sician and burial-tran		resulting in death) Last	Due to (or as a consequence of):			
876	ate b hysic the bi	llcal	•	d			
x 68	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physiclan/Med	IF FEMALE:	ODe Muse subseme of presents			
Вох	death c e attenc	lan	23b. Was decedent pregnant in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
o.	he de the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	Content (specify)		
Δ.	requires that the een signed by th hould be detache	F.	Part II. Other significant conditions co	entributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	use contribute to the cause of death?
ds	luires n sign	d by				1 🗌 Yes	2 No 3 Probably 4 □Unknown
00	law rec as bee 2 shou	Completed				24a. Was an	24b. Were autopsy findings available
Re	The la	mo				autopsy performed?	
tal	10 14	a	25. Was case referred to medical		26. Place of Death	1 Yes 2 1	10 10 20 10
of Vital Records,	Physician: this certific ral director,	To B	examiner? 1 Tes 2 X No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing Hor	ne 5 Residence	6 ☐Other (Specify)
0 4	ding Physician: h. After this certific funeral director,		27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time		28d. Describe how in	jury occurred
Sio	Attending r death. actor: After by the funer	atle	2 Accident investigation		M 1 Yes 2 No		
Division	for Attendiater death. Diractor: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	281. Location (Street City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	S	00 0 W				/-\d
	Hos 24 ho Fun Fun	edical		vsician: To the best of my knowledge, dealiner: On the basis of examination and/or and manner stated.			
	o the	Me	29b. Signature and title of certifier	and marmor stated.	29c. License number	29d. [Date signed (Month, Day, Year)
	- s - o /		mul palm		D651359	Ju	ly 23nd, 2005
7	60		V 1 - 146.1			4	
	- P3			ompleted cause of death (Item 23a) (Type	e. Print)		
	200			ompleted cause of death (Item 23a) (Type		1. 21864	

Levin Tura 218-48-43/8

■ Baltimore, Maryland 21215-0036 Tripoli, Frances Division of Vital Records, P.O. Box 68760, <

		ı,		Marylan	d / Dep	artment	of He	ealth	and Me	ntal Hy	gien	9	
	Physici		1 - State Registrar AMEND TTEM #17 PET 1. Decedent's Name (First, Middle, Last) Frances Tripol)	R FH G8	46 87	<u> 121/03</u> 16	uat C	eath	2 F	2. Date of De	Da	- V - V	26050 3. Time of Death
	/Medio Examir Funeral		4a. Facility Name (If not institution, give street and num 112605 NUSTA 5. Social Security Number 6. Sex	ber) Home 7. Age (In yrs.	last birthday)	4b. City, 1	↑ € (1 Year	If Under	SCALC 24 Hrs. 8	Date of Bir (Month, Da	40	County of Del	
	Director	or	Usual Residence of Decedent 10a. State 10b. County Maryland Harford		Yrs. y, Town or La	ocation	Days	Hours	Min.	9/3/	192	2 N	10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show may injury or other treumatic event, I're Medical Examinar must be notified at ODGE.	Funeral Director	10e. Street and Number	Apt. 1	09	10f. Zip	1001		igin? (Speci	fy Yes or No		U.S.A 14. Race - Am Black, Wh	• nerican Indian,
21215-0036	thin 72 hours afte 9. 9n "naturel", or li Medical Examin	Completed by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	tes:	16a. Dece	1 Yes 2 dent's Usua kind of wor DO NOT us	I Occupa	Specify tion uring mos	-	1	16b. h	Specify: W	
Maryland 21	should be filed wit ind Mental Hygiene s marked other the umatic event, ITS	То Ве Соп	10 0 17. Father's Name (First, Middle, Last) Onofrio Failla			nemake		Ros	e Alfo		, Maidei		
Baltimore, Mai	Pages 1 and 2 shout of Health and int: If item 27 Is nity or other treun		19a. Informant's Name/Relationship (Type, Print) ROSEMARY ROBINSON (Daug 20a. Method of Disposition 1 Daug 20a. Method of Disposition 2 Cremation 3 Removal from S 4 Donation 5 Other (Specify)	20b. P		Susin osition (Name matory or ot	i Dr	ive	Lau	rel,	Mary 20c. L	ocation - City o	20723
Baltin	permit. Page Department of Importent: If any injury or once.	(23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ear	max used the death	7 2	2. Name and	Address Tarr Aben	s of Facil ing- deen	Čargo , Mary	Funer /land	al I	Home, P	
>	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a	STA (ENAL	21	SEA	SE		-		Onset and Death
68760, <	icate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or injury that initiated events c.	or as a consequent									
P.O. Box (The law requires that the death certificate be ate has been signed by the attending physicipage 2 should be detached for use as the broage.	Physician/Medica		th 2 Feta int at time of d	death 3	⊒Ectopic pre ⊒ Other (spe						23d. Date of do Month	alivery Day Year
Records, I	aw requires that is been signed t 2 should be det	Completed by F	Part II. Other significant conditions contributing to dei COROWARY ARTERY D HYPO 7744R0101557			, ,	-			1 🗆 24a. Was	Yes 2	24b. Were a	to the cause of death? Probably 4 Unknown autopsy findings available
Vital	yeicien: The lav is certificate has director, page 2 a	o Be	25. Was case referred to medical examiner?	patient 2	ER/Outpatie	nt 3□ DO.	A Other			1 ☐ Yes Check only	ormed? 2 No one)	death?	s 2 No
Division of	ttending Ph death. ctor: After th the funeral	Certification; T	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined		28b. Time of Injury	of 28	Bc. Injury Work'	at	28 No	d. Describe	how inju	iry occurred	
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physicien: To the la 2 Medicel Exeminer: On the ba and mann. 29b. Signature and title of certifier	sis of examina	tion and/or in	vestigation,	in my opi	inion, de	ath occurred	at the time,	date an	d place, and du	ie to the cause(s)
	0 Sta	te	30. Name and addr ss of person who complete cause SURE(# D##AU #AU! 31. Date filed (Months Qay y 9 gr) 32. F	of death (Item	90 123a) (Type, 225. turg	Print)	DON	45. AVE	344 , HA	VRE D	08	104/2 RACK,	nth, Day, Year) 2005 402/078
DH	Registr	ar	31. Date filed (Month AUG 0 9 2005 32.	rece.	I A	person	9						

ORIGINAL

To the Hospital or Attanding Physician: The law requires that the death certificate be executed

Examine

Physician

/Medical

Examiner

Directo

Funeral

Completed by

Funeral

Director

ō

"natural", o

Maryland 21215-0036

Tilden

Laura Baltimore,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3□Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? Thinks mell Africal from?	Stitisal lung	sulting in the underlyin		23e. Did tobacco 1 Yes 2 24a. Was an autopsy performed?	use contribute to the cause of death? 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	211	1 ☐ Yes 2 N eath (Check only one) Home 5 ☐ Residence	
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	
27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fac fy)	etory, office	28f. Location (Street a City or Town, Star	und Number or Rural Route Number, te)
29a. Certifier Certifying Ph	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	red at the time, date and place tion, in my opinion, death occ	e, and due to the cause(urred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier	Westyn	Ø	29c. License number $\mathcal{DZ} 59$.	33 29d. D.	ate signed (Month, Day, Year) 7-21-05
30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	DANG LANG	EASTEN	MD 21601

Registrar

State

31. Date filed (Month, Day, Year)

2005

32. Registar's Signature

			Please			CK Indelible ink		-	_	
	4		For State	State of Ma	aryland /	Department of Certificate of			000-	26050
			Registrar 1. Decedent's Name (First, Middle, L	asti		Certificate of	Death	2. Date of Deat	g. N. 0 0 5	3. Time of Death
	Physici /Medio		Pauline	L: 41	o th	nornton		Month July	20, 200 S	3 2205 M
	Examir		4a. Facility Name (If not institution, g		. 1	1 0 1	or Location of Death		4c. County of Deal	
	Funeval		Magnolia H. 5. Social Security Number 6.	Sex 7. Ag	e (In gra. last b	pirthday) If Under 1 Year	r If Under 24 Hrs.	8. Date of Birth	Key 9. Bin	thplace (State or Foreign
	Funeral Director		222-22-9348 Usual Residence of Decedent	1□M 21 F	68	Yrs. Months Days	Hours Min.	Jan, 29	71937 N	lary land
	ryland thow		10a. State 10b. County		0	wn or Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
8	he Ma 8a-f s	ecto	MD Ken	+	C_{I}	hestento 101. Zip Code	Wn	1/	og. Citizen of What Co	
3	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show any Injury or other traumatic event, Ite Modical Examiner maters any injury or other traumatic event.	by Funeral Director	10e. Street and Number 211- Keni	nedy Dr	ive	2./	620	'	USA	7
1	deat	ner	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit	
36	s after , or its	y Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give	Чo	1 ☐ Yes 2 12 No				•
21215-0036	2 hour atural	ted b	15. Decedent's	Year or Dates: Education	16	a. Decedent's Usual Occu	upation	.	Specify: 310	/Industry
215	thin 7.	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or	5+)	(Give kind of work done life. DO NOT use retir	red)	ing	1, 1,	1 1 2 1
21	led wi	Con	9			C00	18. Mother's Nam	o /First Middle A	Methodis	+ Camp
and	ntal H ad otl	Be.	17. Father's Name (First, Middle, Las	1 / , ,	R.		1	ah-Car		
Z	should i	၉	19a. Informant's Name/Relationship			9b. Maifing Address (Stree				Zip Code)
Ž	and 2 alth a 27 is ar trau		Paula L	: ttle	2	11-Kenned		Chest	ertown,	ND, 21620
Baltimore, Maryland	of He of He if item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	cemet	of Disposition (Name of tery, crematory or other pl	lace)	Date	20c. Location - City or	
tim	it. Pag rtment rtant: njury c		*4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic	cify)	Rob:	nson's Ceme	1		orason Vi,	He, MD.
Bal	permit. Departr Importa any Inji		21. Signature of Funeral Service Lic	C. 2/01	12140	Monion	FUDIERAL	Home, P.	A. ibridge,	MD 21612
			23a. Parki Enter the disease, or co shock, or heart failure. List on	mplications that cause	the beath. Do	5 10 Mas	on LIVIG TOIN	37 6010	IN PICE	Approximate Interval Between
	Pnysician		fmmediate Cause (Final disease or condition	Ran		dure				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):				>104-
	LXummer	7	Sequentially list conditions,	b. Due to for as	a consequenc	Mallite	5			7,047
	uted d ansit	Examiner	Sequentially list conditions, france in the cause. Enter Underlying Cause (Disease or injury that initiated events							
60,	b be axecuted sician and burial-transit		resulting in death) Last	Due to (or as	a consequenc	e of):				
		dical	•	d						
Box 68	certific iding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of de	livery
	Attanding Physician: The law requires that the death certificate roleath. Geath. sctor: After this certificate has been signed by the attending phy. y the funeral director, page 2 should be detached for use as the	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown		th 3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		Month	Day Year
P.O.	at the d by th	Phy	9 Unknown Part II. Other significant conditions		ut not resulting	in the underlying cause of	aven in Part I	23e Did tob	acco use contribute to	o the cause of death?
ds,	uires l signe ild be o	d by	Hupartans	_				1 □ Y6	s 2 No 3 P	robably 4 Unknown
000	law rec as beel 2 shou	Completed	Coronary	artery	Di	SILSI		24a. Was as autops	24b. Were a	utopsy findings available completion of cause of
Ä	The lavate has	Com					-	perform	ned? 🖊 death?	2 □ No
Vita	yelcian: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:		Io	ther /	th (Check only on		
of	Phys rthis ral dir	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	ent 2□ER/0	. Time of 28c. Inj	4 Nursing Ho	ome 5 Reside 28d. Describe ho	nce 6 Other (Spe w injury occurred	ocify)
ion	nding ath. r: Afte e fune	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	y Year)		ork? □Yes 2□No			
Division of Vital Records,	or Atta iter dea iracto n by th	Certification:	3 Suicide 6 Could not determine	d 286. Place of In	ury · At home, c. (Specify)	farm, street, factory, office	6	28f. Location (St. City or Town	reet and Number or R , State)	ural Route Number,
	spital o	al Ce	29a. Certifier 1 Certifying	Physician: To the best	of my knowled	ge, death occurred at the	time, date and place,	and due to the ca	use(s) and manner a	s stated.
	To the Hospital or Attanding Phye within 24 hours after death. To tha Funeral Diractor: After this completely filled in by the funeral di	Medical			f examination	and/or investigation, in my	opinion, death occur	red at the time, da	ate and place, and du	e to the cause(s)
	To ti withi To ti	Σ	29b. Signature and title of certifier			_	nse number	1	ed. Date signed (Mon	th, Day, Year)
				o completed assess of	tooth /Itom 00-		005887	4	1125/8	>7
			30. Name and address of person who Dr. Paul Donahe	6200 Chu	rch Hi.	ll Road, Che	estertown,	MD 216	20	
	Sta		31. Date filed (Month, Day, Year)	2 7 2005	rar's ignature	S. Spen	d,			
	Regist	ar	301	- 1 1	RECEIVE.					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	arylan			of Hea		nd Me	ental Hy	0.0		0.000
			Registrar 1. Decedent's Name (First, Middle, a	_ast)		- 001	incar	01 00	aur	2	2. Date of De	_	102	3. Time of Death
	Physici /Medic		Katherine	Harmer	Tre	Hin					Month 7	22 Day	05 5	5:00 AM
	Examin		4a. Facility Name (If not institution, g	ive street and number;)		1	Town, or Loc	٨	Death		Λ	unty of Death	. 101
	Funeval		623 Breto 5. Social Security Number 6	Sex 7. Ac		ast birthday)	If Under		Under 24	4 Hrs. 8	B. Date of Bi		ne A	place (State or Foreign
	Funeral Director		196188619	1□M 2 X F	81	Yrs.	Months	Days H	lours	Min.	July 4	th ay, Year) 1924	1 Cou	NC NC
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	/, Town or Lo	ocation							10d. Inside City Limits
	Maryl Iled	ţ	MD Anne	Arundel			Ar	nold						1 ☐ Yes 2X No
	a or 28s	I Director	10e. Street and Number 623 Breton Pla	ce			10f. Zip	Code 21012	2			10g. Citizer	of What Cou USA	ntry?
936	within 72 hours after death with the Maryland fene. than "natural", or Items 23a or 28a-f show the Medical Eraminar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1	?	1	Was Deced If Yes, spec		nic Origir Nexican, F	n? (Spec Puerto Ri	ify Yes or No ican, etc.)		Race - Ameri Black, White, pecify:	
2-0	72 ho 'natur	eted	15. Decedent's (Specify only highest			(Give	kind of wor	l Occupation	n ng most o	of working	7	16b. Kind	of Business/Ir	ndustry
21215-0036	within ane. than *	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	_	до NOT us fice	e retired) Manage	er			Phys	sician'	s Office
N	i Hygi Hygi other	Be Co	17. Father's Name (First, Middle, La	st)				18.	. Mother's	s Name (First, Middle	, Maiden Su	mame)	
ylar		To E	William Frederi	ck Harmer						a Lee				
Maryland	12 ha 7 ls		19a. Informant's Name/Relationship Gene Trettin/Hu				-				Route Numb		own, State, Zi)1 2	p Code)
	Heal Heal tem 2		20a. Method of Disposition 1 Burial 2 XCremation 3	☐Removal from State	, c	lace of Dispo emetery, crei	osition (Nan matory or o	ne of ther place)		July Da	23,	20c. Loca	ion-City or T	
Baltimore,	permit. Pages Department of Important: If I any injury or once.		* 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lin	-	Pie	2: E	2. Name an	d Address o	f Facility Sons	, P.Z	05 A. Sev	erna 1		neral Home
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that cause	d the death								alk, I	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	E E	mol	27 75	2m							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequ	uenge of):		1						
ŀ.		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due 15 (or a	в а сопваці	uence of):								
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	С.										
90,	ste be exe tysician au he burial-t		resulting in death) Last	Due to (or as	s a consequ	uence of):								
68760,	icate I physic	edical		d										
.O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 🗌 Fetal	Ideath 3	⊒Ectopic pr ⊒ Other <i>(sp</i>					230	I. Date of deliv Month	rery Day Year
s, P.	es that tigned by	by Ph	Part II. Other significant condition	s contributing to death	but not resu	ulting in the u	inderlying c	ause given ir	n Part I.		23e. Did	tobacco use	contribute to	the cause of death?
ords	w require been sig should b										1 🗆	Yes 2□1	10 3 20	bably 4 □Unknown
Il Record	The lar ate has page 2	Completed								_	24a. Was auto perf 1 Yes		24b. Were autoprior to condeath?	opsy findings available ompletion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	2	ER/Outpatie	-1 2 DC	Othor	6. Place o 4 □ Nurs		Check only	1	Other (Speci	(4.1)
of	g Phys er this eral dir		1 Yes 2 70	1 ☐ Inpat 28a. Date of Inj (Month, D	urv	28b. Time o		8c. Injury at Work?	4 LI RUIS			how injury o		19/
sion	or Attending I after death. Director: After in by the funer	atlo	2 Accident 5 Pending investiga	tion			М	1 🗌 Yes	2 🗆 No					
Division	ial or Attend s after death al Director: / ad in by the f	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 288. Place of II	njury - At ho atc. <i>(Specif</i>)	ome, farm, st	reet, factory	, office		28		(Street and N wn, State)	lumber or Rur	al Route Number,
	To the Hospital of within 24 hours all To the Funeral D completely filled in	edical		Physicien: To the bes siminer: On the basis and manners	of examinat									
)	To the vithin Comp	M	29b. Signature and Little of certifier	6 lev)		290	License nu	mber	94		29d. Date s	Jalah	Oc S
			30. Name and address of person	no completed cause of	death (Item	23а) (Туре,	P(21)	sel	A	re	A	una	olij 1	no
	Sta Regista		31. Date filed (Month, Day, Year)	2005 32. P gist	trar's Signa	ture	book							

LL	JAH WAL	KER	For State Registrar	State of I	Marylar		artment of rtificate of		nd Mental H	lygiene Reg. No	0.0	260	E 1.
	Physic		1. Decedent's Name (First, Middle, Elijah	Last)	Walk	er			2. Date of Month	Death Da	v Year	3. Time of	Death P M
	/Medi Examir		4a_Facility Name (If not institution 524 NORTH CHARL	give street and number ES STREET	ÄPT.12	2 15	4b. City Town	MORE CI	TY TY	4c	. County of Death		
	, Funeral Director		5. Social Security Number 243-58-2714	5. Sex 7. 1 X M 2 ☐ F	Age (In yrs. 65	last birthday) Yrs.	If Under 1 Yea Months Day:		Hrs. 8. Date of (Month, 8 / 0	Birth Day, Year) 5/193	9. Birth Cou Rale	place (State o ntry) eigh, l	
	Maryland	ō	Usual Residence of Decedent 10a. State 10b. County MD			ty, Town or Lo						10d. Inside Ci 1 ∑ Yes	
	with the Name or 28a-	i Director	10e. Street and Number 524 North Cha	ırles Str	eet	#1215	10f. Zip Code 21 2	201		10g. Cit	tizen of What Cou		
920	72 hours after death with the Maryland natural, or Iteme 23a or 28a-f show dical Examinar mat be nutified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force d 1 Tyes 2 If Yes, Give Year or Date	s? X No		Was Decedent of II Yes, specify Cu	ban, Mexican,	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ameri Black, White, Specify: B1		
21215-0036	d within 72 jiene. r then "ne ine Medic	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0·12)	Education grade completed) College (1-4d	or 5+)	(Give	dent's Usual Occi kind of work don DO NOT use retii ntenanc	e during most o red)	of working ervisor	16b. K	Radio	,	on
Maryland 3	uld be filed fental Hygior rked other tic event, Il	e e	17. Father's Name (First, Middle, La Isaac Walker	?st)					s Name <i>(First, Mid</i> lice Pet				
	and 2 should b alth and Ment 127 Is marked er traumatic e		19a. Informant's Name/Relationship Peter T.Walke				_		or Rural Route Nu ge Rd. I	Monto	omerv '	Villa	ge,Mc
Baltimore,	iit. Pages 1 and 2 should b artment of Health and Menis ortant: If Item 27 is marked injury or other traumatic e		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		te C	cemetery, crei	esition (Name of matory or other po f Heav	en 7/	Date 25/05		ocation - City or T lver Sp		Md
Balt	permit. Pag Department Important: any injury o		21. Signaturi Fuñeral Service Li	inde					LDI FUN Blvd.S		SERVIC r Sprin	E,P.A ng,Md2	0910
	Physician //Medical Examiner the priviping and physician and physician and physician and physician are physician and physician are physician and physician are physician and physician are physician	i Examiner	23a. Part1. Enter the disease, or c shock, or heart lailure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (or	as a consequence as a c	quence of):			duscular	^	ease	Approximat Interval Bet Onset and I	ween Death
.O. Box 68760,	death certific a attending p od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	n 2 ☐ Feta t at time of d	ıl death 3 [Ectopic pregnan	су		_	23d. Date of deliv Month	*	Year
Δ.	requires that the diener signed by the hould be detached	۵	Part II. Other significant condition	s contributing to deat	h but not res	ulting in the u	nderlying cause g	pven in Part I.			use contribute to t		leath? Jnknown
Division of Vital Records,	The law ete has b paga 2 s	Completed							24a. W ar pr 1 Ye	itopsy erformed?	death?	impletion of ca	
f Vita	Physician: This certifice ral diractor, p	To Be	25. Was case referred to medicat examiner? **Pos** 2 \sum No	Hospital:	atient 2	ER/Outpatier	nt 3 DOA		of Death (Check on ing Home 5 ☐ R		eXOther (Speci	fy) AT S	SCENE
ion o	ding h. After fune		27. Manner of Death 1 Satural 5 Pending 2 Accident investiga		njury Day Year)	28b. Time of Injury	W	uryat ork? ⊒Yes 2 ∐No	28d. Descri	oe how inju	ry occurred		
Divis	o the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of building,	Injury - At h	ome, farm, str	eet, factory, office	•		n (Street ar Town, State	nd Number or Run e)	al Route Num	ber,
	Pru 4	edicai	29a. Certifier (Check out) One 1 Certifying 2 Medical Ex	Physician: To the be caminer: On the basis and manner	s of examina	owledge, death tion and/or in	h occurred at the vestigation, in my	time, date and opinion, death	place, and due to to occurred at the tin	ne, date and	d place, and due t	o the cause(s)
	To the to the complete	Σ	29b. Signature and title of certifier	w				O.C.M.E		JUI	te signed <i>(Month</i> , LY 18,200	0ay, Year) 05	
_	•		30. Name and address of person w	no completed cause of	111	1 PENN	STREET,	BALTIM	ORE, MARY	LAND 2	21201		
1	Sta Registr		31. Date filed (Month, Day, Year)	2005	istrar's Signa	sture for	we						

			1 - For State Registrar	State o	f Marylar		artment of H		nd Mental		ne 2.005	26055
	Physici	an	1. Decedent's Name (First, Middle	, Last) nes					Mont	of Death h	Day Yea 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, or	Location of			4c. County of De	
			Holy Cross Ho	-			Silver				Montg	
	Funeral Director		5. Social Security Number 578-26-1095	6. Sex 1 □ M 2 □ F	7. Age (In yrs. 7		If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date (Mon	h, Day, Ye		irthplace (State or Foreign Country) shington, DC
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty. Town or Lo	nation					10d. Inside City Limits
	shon	ŗ.			100.01							1 ☐ Yes 2 ██No
	the N	Director	Maryland Montg	omery		Wheato	10f. Zip Code		<u> </u>	10a.	Citizen of What (Country?
	with 3a or		12102 Judson 1	Road			20902			"	JSA	,
	death	Funerai	11. Marital Status		edent Ever in U	.S. 13.	Was Decedent of Hi	ispanic Origin	n? (Specify Yes	or No-		nerican Indian,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Marylan Examination at the motified at	by Fur	1 ☐ Never Married 2 🗷 Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Formed 1 ☐ Yes If Yes, Gir Year or D	2 [3 XNo ve		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	rueno nican, et	v.)	Specify:Wh	
ğ	2 hou	ted	15. Decedent			16a. Dece	dent's Usual Occupa	ation	of warding	16b	. Kind of Busines	s/Industry
215	thin 7 e. an "n	Completed	(Specify onfy highes Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired))	or working			
7	filed wi Hygien other th ent, Ire	Con	12			Hom	emaker		N		own Home	
		Be	17. Father's Name (First, Middle,						s Name <i>(First, N</i>			
<u> </u>	should be and Mental s marked o umatic eve	1º	Edgar P. Will 19a. Informant's Name/Relationsl			10h Mailie	ng Address (Street a		lla M. D			Zin Code)
<u>s</u>	d 2 sl th and th and traur		Ernest H. Wines		4		2 Judson					Zip code)
ē,	Heal Heal Hem 2		20a. Method of Disposition	o, nabban	20b. F	Place of Dispo	sition (Name of	-> 1	Date	20c	Location - City	or Town, State
ē	ent of		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)				natory or other plac aven Cemete		July 2' 2005		ver Spr	ing, Maryland
Baltimore,	perrit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone.		21. Signature of Funeral Service		0		Name and Address Francis J 500 Unive	. Coll		eral	Home Ind	2
			23a. Part1. Enter the disease, or	complications that of	caused the deat						ver spr	Approximate
	Pnysician		shock, or heart failure. List Immediate Cause (Final	only one cause on e Seps:								Interval Between Onset and Death Sudden
	/Medical		disease or condition resulting in death)	a	(or as a conseq	uence of):						Sudden
	Examiner		Sequentially list conditions,		ration :		nia					Day
	D #	iner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uence of):						
	ecute and I-trans	Examine	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):						
8760,	sate be executed bhysician and the burial-transit	aiE			(0. 00 2 00004	,231123 27,1						
687	ate ohy:	edicai		d								
ŏ	eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnancy				23d. Date of d	elivery
n n	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (specify)				Month	Day Year
J.	at the de d by the etached	Phy	9 ☐ Unknown Part II. Other significant condition			udimo in the co		n in Bost I	220	Did tobaco	no use contribute	to the cause of death?
ecords,	The law requires that the death certifit te has been signed by the attending p page 2 should be detached for use as	by	Chronic Renal		eath but not les	alang in the a	ndenying cause give	an an Fauti.		1 Tes		Probably 4 Hunknown
Ö	s been s should	Completed							24a.	Was an	24b. Were	autopsy findings available completion of cause of
r	The la	E O							_	autopsy performed ∕es 2∑	? death?	es 2 No
Vital		BeC	25. Was case referred to medical examiner?					26. Place o	f Death (Check			
o	≥ .g p	Jo.	1 ☐ Yes 2 🔀 No	Hospital: 1 🔀	Inpatient 2	ER/Outpatier					6 □Other (Sp	ecity)
D D			27. Manner of Death 1 X Natural 5 ☐ Pending	9	of Injury th, Day Year)	28b. Time of Injury	Work	(?		ribe how in	njury occurred	
<u> </u>	e te de	cati	2 Accident investig	ot bo	of Injune At h	omo form etr		Yes 2 □ No		ion /Street	t and Number or I	Rural Route Number,
Division	i or Al after of Direction by	Certification:	4 Homicide determ	inad 200. Flace	ing, etc. (Specif	y)	eet, factory, office			or Town, St		Turai rioule rumber,
	To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: After completely filled in by the fune	edical C		g Physician: To the Examiner: On the b								
	o the	Me	29b. Signature and title of certifie				29c. License	number		29d.	Date signed (Mo	oth, Day, Year)
	->-0		> gum	m			D32	332		J	uly 22,	2005
	6		30. Name and address of person Suresh K. (0, Silv	er Sp	ring, MD	20902
	Sta Registr		31. Date filed (Month, Day, Year)		legistrar's Signa				, , , , , , ,	12		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** July 2005 10:12 A Walsh 20 Mary /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2√2 F Yrs. 66 May 31,1939 215-80-5073 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural, or items 23e or 28e-f show the Medical Examinar must be notified at Y Yes 2 □ No Silver Director Md. Montgomery Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15309 20904 Layhill Rd. U.S.A death , Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž No Specify: White þ 3 Widowed 4 Divorced "naturai", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any intermed of their traumatic event, The Medic once. completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 'n N/A None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1315 Orchard Way Robert Claxton(Guardian) Frederick, Md. 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chambers Crematory July26,2005 Riverdale, Md. 22. Name and Address of Facility Chambers Funeral Home & Crematorium, P.A 21. Signature of Funeral Service Licenses 5801 Cleveland Ave. Riverdale, Md. Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to Mas a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the for use IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 No 1 Yes Hospital or Attending Physicien: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2X No 1 Tes 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Inpatient Date of Injury (Month, Day Year) 28c. Injury at Work? the funeral 28b. Time of 28d. Describe how injury occurred 27. Manger of Death After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Diractor: A 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHAL DR CHEVER 14 VENIS JAME AtE 31. Date filed (Month) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Reg. No Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Whalen, Jr. 24 2005 8:10 Ju1v/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Genesis Eldercare - Spa Creek Annapolis Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**XX**M 2□F Months Days Hours Min Director 84 1920 Pennsylvania 168-16-2643 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Anne Arundel Annapolis 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 21401 USA 606 Cutter Court death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other then any injury or other treumstic event. College (1-4or 5+) Elementary/Secondary (0-12) 12 Technical Writer DOD 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John C. Whalen Alice Hengott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 606 Cutter Court, Annapolis, MD 21401 Karen Whalen (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 7-26-2005 Crownsville, MD • 4 □ Donation 5 □ Other (Specify) Maryland Vet. Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A pnce. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 herme ! Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) □Yes 2□No detached Division of Vital Records, P.O. 9□ Unknown the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ þe 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 42 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After To the Hospitel or Attending 1 Matural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death the 6 Could not be determined 3 🗍 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a

To the Funeral C

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and tile of certife 29d. Date signed (Month, Day, Year) 29c. License number 30. Name, and address of person who con ed cause of death (tem 23a) (Type, Print) no 2108

State Registrar 31. Date filed (Month, Day, Year)

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32. Redistrar's Signature

2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 5 2. Date of Death Decedent's Name (First, Middle, Last) July **Physician** $2\bar{2}$ 2005 12:42P M Sterling H. Winslow /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Elder Care @ Spa Creek Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months 1**X**]M 2□F Hours 578-12-9056 85 Yrs. Director Oct 23 1919 D.C Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or Items 23a or 28a-f show direct cust be notified at 1X Yes 2 □ No Maryland Anne Arundel Annapolis Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 21403 3300 Arundel on the Bay Rd. USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "naturel", or Iter 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black ρ other treumatic event, Il's Mudical Exa-3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Company Self Employed 5th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace King William Winslow ျှ 21403 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m eny Injury or other treum <u>once.</u> Louvenia Winslow(Wife) \$300 Arundel on the Bay Rd. Annapolis, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hill Crest Cemetery 7-29-05 Annapolis, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Wm. Reese & Sons Mortuary, P.A. Larry D. Keese 1106 783 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) endiac 1/tonia **Physician** /Medical Que to (or as a consequence of) **Examiner** oronale Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and thed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown à cate has been signed, page 2 should be det significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 No 2 X No 1 Yes 1 ☐ Yes Physicien: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: e Hospitel or Attending Pl 24 hours after death. e Funeral Director: After ti 1 Natural 5 Pending 1 🗌 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 24 hours a 29a. Certifier 🔏 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a itle of certifier s of person who completed cause of death (Item 23a) (Type, Print) te. 23/ Annapolis, m.D. 2140/ hopra m. D. 600 Rida JUL 2.6 2005 istrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2005 Ju1y 15, 9:41 A N Elbert Williams, Jr. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Charles County Waldorf, Maryland 5405 Minnow Court Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/16/1948 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min Hours 1√2 M 2□ F Yrs Charlotte, NC Director 577-66-3240 57 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-fehow other traumatic evant, the Medical Examiner must be notified at Charles Waldorf X Yes 2 No Maryland Director 10g. Citizen of What Country? United States Street and Number 10f, Zip Code 20603 10e. Street and Number 5405 Minnow Court 5 "natural", or itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify Black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Je filed wh. The Hygiene. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Communication 12 Manager permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Important: If Item 27 Is marked other any injury or other traumatic evant. It 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Creola Hilton James Elbert Williams, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7806 Drum Point Lane, Clinton, MD 20735 James D. Williams / Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Harmony Cemetery N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/23/2005 Landover, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Pope Funeral Homes, P.A., 5538 Marlboro Pike Inmens ann Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -unturec disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day ğ 4□Pregnant at time of death 5 Other (specify) P.O. I detached signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Tes 2 No 3 Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 1 ☐ Yes 2□ No 2X No Hospital or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 1 X Yes 2 ☐ No ihis funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After t Certification: Injury Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Eunarai I 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated within 2 the 29d. Date signed (Month. Day, Year, 29c. License number 29b. Signature and title of dertifier D005119 10 npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co 20746 5001 Silver Hill Road, Suite 101, Suitland, MD M.D. Emerson Cornell, 31. Date filed (Month, Day, Year) 2. Registrar's Signature JUL 2 6 2005 Registrar

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Second S	V	ocuted nd transi	ami	triat initiated events C.						4		
FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No Nonth Day Year 1 Year Yea	2 3	ou, be exected a	Ě	resulting in death) cast	Due to (or as a cons	equence of):						•
FEMALE: 23d. Date of delivery 23d. Date of deliv			dica	d.					-			
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The standard of the standard o		death death e atter d for u	ciar	in the past 12 months?	4 ☐ Pregnant at time of			cy		1		
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The standard of the standard o	0	Ord requir een s	ted						1	Yes 2 No	3 Proba	ably 4 Onknown
25. Was case referred to medical examiner? The property of	80	2 8 8	0						auto	psy	prior to con	osy findings available npletion of cause of
The property of the property	\ . · · · ·	T. The Tricate icate	S						1 ☐ Yes	2 No	1 Yes	2 No
To the part of the	T :	Siciar certificacto	9 Be	examiner?	spital: 1 (Innationt 2	□ EP/Outpotion	30 004 0	thee			har (Crasife	
Solution	B	Phy g Phy er this	n i	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inju	ury at	1)
Signature and dittle of certifier 289. Place of Injury - At home, farm, street, factory, office 281. Location (Street and Number or Rural Route Number, City or Town, State) 281. Location (Street and Number or Rural Route Number, City or Town, State) 282. Location (Street and Number or Rural Route Number, City or Town, State) 283. Suicide 4 Homicide 5 Could not be determined 6 Could not be determined 284. Location (Street and Number or Rural Route Number, City or Town, State) 285. Location (Street and Number or Rural Route Number, City or Town, State) 286. Place of Injury - At home, farm, street, factory, office 287. Location (Street and Number or Rural Route Number, City or Town, State) 288. Place of Injury - At home, farm, street, factory, office 288. Place of Injury - At home, farm, street, factory, office 288. Place of Injury - At home, farm, street, factory, office 289. Location (Street and Number or Rural Route Number, City or Town, State) 290. Location (Street and Number or Rural Route Number, City or Town, State) 291. Location (Street and Number or Rural Route Number, City or Town, State) 292. Location (Street and Number or Rural Route Number, City or Town, State) 293. Location (Street and Number or Rural Route Number, City or Town, State) 294. Location (Street and Number or Rural Route Number, City or Town, State) 295. Signature and title of certifier 296. Signature and due to the cause(s) and manner as stated. 296. Location (Street and Number or Rural Route Number, City or Town, State) 297. Location (Street and Number or Rural Route Number, City or Town, State) 298. Signature and due to the cause(s) and manner as stated. 298. Signature and due to the cause(s) and manner as stated. 299. Date signature and title of certifier 299. Date signature and title of certifier 290. Date signature and title of certifier 291. Date signature and title of cer	3	inding ath. r: Afte	atio	1	(Month, Day Year)	injury						•
The stand of the transport of the stand of t		r Atta	tific	dataminad	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	eet, factory, office		28f. Location City or To	(Street and Num wn, State)	ber or Rural	Route Number,
29a. Certifier (Check only one) 29m Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2	urs aff	S									•
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 01, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Control of the C	M	Host 24 hor Funa tely fil	lical	(Check only 2 Medical Examine	er: On the basis of exami	nowledge, death nation and/or inv	occurred at the restigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time	cause(s) and m , date and place,	anner as sta and due to	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Secretary And 9707 Medical Course of Dough #300 Personal And 20850	72	o tha vithin o tha	Mec				29c. Licer	se number		29d. Date signe	ed (Month, E	Day, Year)
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NI GOVERN COTES AND 9707 Medical Courses Down #300 Particulla MD 20850		•		30. Name and address of person who com	pleted cause of death (It	em 23a) (Type, I	Print)			0		
GENTLE H. SOLDS, 1017 LOTT CONCENT CONTENTS POLICE TO THE		71)	GEORGE A. SOTOS, 1	40 9707 M	redical	Center	Drive, +	+300 Re	xhuille	MD	20820
State Registrar AUG 0 9 2005 31. Date filed (Month, Day, Year) 32. Figistrar's Signature					32. Hagistrar's Sig	nature	ente					

Anwend item#11, per Inf. 0854, 4/5/06 TT Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** William 2005 Young July 18. 7:52p/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Holy Cross Hospital Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1₩ M 2□ F 56 Director August 24 1948 Washington, D.C 220 50 9176 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 9901 East Light Drive "naturat", or Itams 23a 20903 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours aftar 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed + Diver Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should ba filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injucy or other treumatic event, ILM Manones. Elementary/Secondary (0-12) College (1-4or 5+) Specialist Computer Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clara Lillian Costenbader Arthur Edward Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9901 East Light Drive Silver Spring, Maryland 2090320b. Place of Disposition (Name of Cametery, crematory or other place)

20c. Location - City or lown, State Clara L. Young / Mother 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Ft Lincoln Crematory 7/26/2005 Brentwood, Maryland 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardial Infarction Physician 15 Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Year Dav 4 Pregnant at time of death 5 Other (specify) 2 No should be detached 9 Unknown Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably A ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes Ž⊡No 2 □ No 1 TYes Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 the Hospital or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) onel and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, Maryland 20910 Paul B. Baker, M.D. 32. Begistrar's Signature State 2 6 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

			State		artment of Health			ene g. N2 0 0 5	26062		
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death		
85	Physicia	200	Gilbert L. Zimbro				Month July	25 2005	8:05 A ^M		
C. 1	/Medic Examin	-	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	on of Death		4c. County of Deat	h		
7 × 1/4			8433 Woodward Street		Savage			Howard			
P. Ca	Funeral		1/ Y M 2□ E	rs. (ast birthday) Yrs.	Months Days Hour		8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign buntry)		
	Director		236 38 4368 76 Usual Residence of Decedent	113.			6/11/192	y west	Virginia		
	/land			City, Town or Lo	cation				10d. Inside City Limits		
	Man	to	MD Howard	Fulton					1 ☐ Yes 2 🔀No		
	th the	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?		
	ath wi	ral	12626 Lime Kiln Road		20759	0.1.0.10		USA 14. Race - Ame	rices lodies		
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces? 15. Yes 20 No.	1	Was Decedent of Hispanic f Yes, specify Cuban, Mexi	ican, Puerto	Rican, etc.)	Black, Whit			
36	irs aft	by F	1 □ Never Married 2 □ Marned 1 □ □ Yes 2 □ No 19 If Yes, Give Year or Dates: 195	3	1 ☐ Yes 2 🙀 No Spec	cify:		Specify: Wh	ite		
21215-0036	72 hours after death with the Maryland naturel; or teme 23s or 28s-f show disal Examiner must be notified at	eg l	15. Decedent's Education (Specify only highest grade completed)	16a, Dece	dent's Usual Occupation kind of work done during n	most of works	no 1	6b. Kind of Business	/Industry		
21	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. I	DO NOT use retired)						
	filed within Hygiene. sther then "		12 17. Father's Name (First, Middle, Last)	Clain	ns Investigat		(First, Middle, M	.S. Navy			
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7	should and Men marke umatic	P	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Num	ımber or Rura	il Route Number,	City or Town, State,	Zip Code)		
	alth a		Mary Jo Ardoin/Sister	1262	26 Lime Kiln	Road	Fulton,	MD 20759)		
Baltimore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other then, "naturel; or Iteme 23s or 28s-1 show if item 27 is marked other then," naturel; or Iteme 27 is notified at or other treumatic event, the Medical Examinar must be notified at	- 1	254. Million of Disposition	b. Place of Dispo cemetery, crer	sition (Name of natory or other place)		Date 2	20c. Location - City or	Town, State		
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	20 E • 0		23a. Part1. Enter the disease, or complications that caused the d	003.0					Amerovimeto		
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sio	Attending in death.	catio	2 Accident investigation		M 1 Tyes 2	-	and Leastine (Ct	and and Mumber of C	hural Pouta Numbos		
Division of Vital Records,	after death after death Director: d in by the	Certification:	4 Homicide determined 28e. Place of Injury - A building, etc. (Sp.	At home, farm, st ecify)	reet, factory, office		City or Town	reet and Number or F n, State)	lurai nobie Number,		
	To the Hospital or Attending Physician: within 24 horus after death. To the Funeral Director: After this certific completely filled in by the funeral director.		zea. Certifier (Mcertifying Physician, To the best of my	knowledge, deal	h occurred at the time, dat	le and place,	and due to the ca	الماستون المسافرة	s stated.		
	ne Ho	edicai	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	nination and/or in	vestigation, in my opinion,	, death occur	red at the time, da	ate and place, and du	e to the cause(s)		
	To the To the COMP	ž	29b. Signature and title of certifier	5 5	29c. License numb			9d. Date signed (Mon	th. Day, Year)		
)			Kopense Mune	MD	1) 36.	246		1/25/0	7)		
02	`		30. Name and address of person who completed cause of death	(Item 23a) (Type,	D36. Print) - Rel Glen	Burn	ie und	2/0	60		
	St	ate	31. Date filed (Month, Dav. Year) 32. Refistrar's S	ignature		~~~					
	Regist		JUL 2 7 2005 Alexan	· K	barles						

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 2. Oate of Death Decedent's Name (First, Middle, Last) 07/24/2005 Year Physician РМ 3:00 Charlotte B. Zeman /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Parkton 1004 Old Barn Road If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/31/1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 1 M 2 XF Michigan 88 370-05-8559 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County ?7 is marked other than "naturel", or Items 23a or 28a-f show treumatic event, Ite Medical Examiner must be motified at 1X Yes 2 □ No Completed by Funeral Director Maryland Baltimore Parkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21120 USA 1004 Old Barn Road Pages 1 and 2 should be filed within 72 hours after death vent of Heatlh and Mental Hygiene. Int: If item 27 is marked other than "naturel", or Items 236 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 ♥ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Flementary/Secondary (0-12) Payroll Clerk Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lillian Weigle Earnest Battan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tret QDG9. 1004 Old Barn Road Parkton, MD 21120 Mary Jo Vogt/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulancy Valley
Memorial Gardens 07/28/2005 Timonium, MD 20a. Method of Disposition
1X Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final MOSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 010101 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗙 No the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ eq pinous 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2X No 2 No 1 Yes Hospitel or Attending Physicien: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 🔀 No 1 🗌 Inpatient this Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ernestine istrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of I	Marylan		artment e rtificate			and M		giene Reg. No.2	105	26061
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death				
	Physici /Medi		Helen Elizabeth	Augsbu	ırger		Augu				August	5, 20		10:00 PM
	Examir		4a. Facility Name (If not institution, give street and number)						Location o	of Death			nty of Death Ltimor	
			Brightwood Nursi 5. Social Security Number 6. Sex		Age (In yrs. I	last birthday)	Balt If Under 1		If Under:	24 Hrs.	8. Date of Birt (Month, Day		9. Birtho	place (State or Foreign
н	Funeral Director			M 212 F	87	Yrs.	Months I	Days	Hours	Min.	Sept. 2	5,1917	Mar	yland
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	the A	Director	10e. Street and Number				10f. Zip C					10g. Citizen	of What Cou	ntry?
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980	be filed within 72 hours after death with the Maryland hat Hyglene. ed other than "netural", or Iteme 23a or 28a-f show event, I're Mudical Exarcitive rust be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	ss? X) No		Was Deceder If Yes, specify 1 ☐ Yes 2	y Cubar	spanic Ori , Mexican Specify:	gin? (Spe i, Puert <i>o</i> I	cify Yes or No- Rican, etc.)		lace - Americ Black, White, cify: W	
2-0	72 ho	eted	15. Decedent's Edu	cation e completed)		16a. Dece (Give	dent's Usual (kind of work DO NOT use	Occupa done d	tion uring mos	t of workin	ng	16b. Kind of	Business/In	dustry
21215-0036	within ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		_{DO NOT us} в Imemake					Own :	Home.	
	filed Hygi ther		9th Grade 17. Father's Name (First, Middle, Last)			110	manocice		18. Mothe	er's Name	(First, Middle,			
an	Mental Mental arked o	To Be	Lewis Zeller						Anı	па	Sann			
Maryland			19a. Informant's Name/Relationship (Ty		+ a + 1	F	-				Route Numbe			o Code)
	t and tealth om 27 ther tr		Mrs. Jean Powers 20a. Method of Disposition	(daugh	20b. P	lace of Dispo	sition (Name	of	1		utimor	20c. Locatio		own, State
nor	Pages nent of H int: If ite		1 XBurial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	lemoval from Sta	ate C	emetery, cre .kwood	natory or oth	er place		8/10/	2005			laryland
3altimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service License	90	7000	2:	2. Name and	Addres	s of Facilit	ySch	imunek	Funera	l Home	
	<u>0</u> .0 ≒ ∈ ol		222 Part Enter the disease or compli	ications that cau	sed the death						utimor r respiratory ar		21230	Approximate Interval Between
0,	Cate be executed physician and physician and the burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of):								Onset and Death			
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O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Feta et at time of d	Ideath 3	⊒Ectopic preç ⊒ Other (spec						Date of deliv Month	rery Day Year
0	urres that signed by Id be deta	þ	Part II. Other significant conditions con	ntributing to deal	th but not res	ulting in the u	inderlying cau	ise dive	n in Part I			obacco use c res 2□No		the cause of death? bably 4 Suaknown
Records,	hysician: The law require nis certificate has been sig t director, page 2 should b	Completed	Urinay	5 tra	et 1	nfee	Pro-				24a. Was autor perfo		b. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
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of \	Physician: this certific ral director,	2	1 Yes 2 No	Hospital: 1 ☐ Inp		ER/Outpatie		c. Injury	4		ne 5 Resident			fy)
ono	fune fune	tion	1 Natural 5 Pending investigation	28a. Date of (Month,	Day Year)	Injury	M	Work	n. ∕es 2□					
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	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	29a. Certifier (Check only one)							stated. to the cause(s)					
	To the within 2 To the complet	Me	29b. Signature and Mile of certifier	\			29c.	License	number			29d. Date sig	ned (Month,	Day, Year)
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1	0		30. Name and address of person who c	mpleted cause	C	1	Print)	2.0	An	RI	Rulding	# 200	6 1-	21220
	St	ate	31. Date filed (Month, Day, Year)	32. 769	gistrar's Signa	ature	102/00	a	0-18	x) /-	witting	200	15011	21239
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear **Physician** Mary J. Ahern /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and nymber) **Examiner** NIA ALTIMORE GOOD SAMARITAN HUSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 1-20-26 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 TF 76 Md 257-34-6632 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 27 is marked other than "neturel; or items 23e or 28e-f show treumatic event, the McAlcal Examinal must be notified at Yes 2 No Director Baltimore Md 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21239 1532 Ramblewood Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel" or increase in jury or other treumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 5+ 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Ouillian Charles King Janes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annapolis, MD 21401 20 Jefferson Place Juanita Parry/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 X Donation 5 ☐ Other (Specify) Ronald S. Wade, Director per dvr State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNKNOWN Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner the attending physicien and ned for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2□ No 1 Tyes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death. Director: Aft 1 TYes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Implicate Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AUGUST 2, 2005 5601 LOCH RAVEN BOULEVARD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASHIDHARAN, MD BALTIMORE, MARYLAND KALATHIL 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 0 2005 Registrar

			For State Registrar	State of M	-	epartment d Certificate	of Health and of Death	Mental Hy	giene Reg. N2 0 0 5	26066	
	- 211	- 4	1. Decedent's Name (First, Middle, Las	it)				2. Date of De. Month	ath Day Ye	3. Time of Death	
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	Examin		4a. Facility Name (If not institution, give			4b. City, To	wn, or Location of De	ath	4c. County of C		
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	Funeral Director		5. Social Security Number 6. S 217-28-8134		ge (In yrs. last birtho 74 Yr	Months E	Year If Under 24 H Days Hours Mi		. 1931 Ma	Birthplace (State or Foreign Country) aryland	
	pur *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town o	or Location				10d. Inside City Limits	
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	28a-	Director	10e. Street and Number	corge 3		10f. Zip Co	ode		10g. Citizen of Wha	t Country?	
	3a or		8105 Sonar Road				20735		U.S.A.		
036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland If Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Mental Hygiene are 1 start 1 is marked other than "naturel", or Items 23a or 28a-f ehow other traumatic event, the Modical Examination into Indition at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give A Year or Dates:	?	13. Was Deceder If Yes, specify	nt of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No arto Rican, etc.)		American Indian, Vhite, etc. White	
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Maryland 21215-003	d 2 st h and 7 te n traun	()	19a. Informant's Name/Relationship (Constance Marie								
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Baltimore,	permit. Peges Depertment of Important: If It eny injury or c		21. Signature of Funeral Service Licer	ise		22. Name and	Address of Facility	Lee Funer		Inc. aton, MD 20735	
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<u>s</u>	Attendi death. ctor: A y the fu	catl	2 Accident investigatio		njury - At home, farn	М	1 Yes 2 No	204 Location /	Ctroot and Number of	or Russ I Route Number	
Ω	el or Al s after o sl Dirac ed in by	Certification;	4 Homicide determined	OTTICE	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exer	nysician: To the besi miner: On the basis and manners	of examination and/	death occurred at or investigation, in	the time, date and plan my opinion, death or	ace, and due to the courred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)	
	To ti withii To ti comp	W	29b. Signature and title of certifier	1		290,4	License number		29d. Date signed (A	fonth, Dey, Year)	
	1 /	1	0	17			D1991		2/9/0	y	
14			30. Name and address of person who	completed cause of	death (Item 23a) (T	ype, Print)	11-4	IN FA	- 1/1	6 Mm Dering	
	J		Transh /h/2	32 DW	(//U/	1 dalab	0 /12	105 11	1 Kuller	00 199	
	Sta Registr		31. Date filed (Month, Day, Year)	2005	trar's Signature	Societies					

State of Maryland / Department of Health and Mental Hygiene 1- State AMEND ITEM #10e&f&19b PER FH & SAMO & 17/05 all Reg. No. 2. Date of Death I. Decedent's Name (First, Middle, Last) ^{Day} 2005 AUGUST 9, **Physician** JAMES F. BERRY 4:00 A.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 102 LOUISE TERRACE GLEN BURNIE ANNE ARUNDEL 8. Date of Birth (Month, Day, Ye AUG. 28, 9. Birthplace (State or Foreign Country)
NORTH CAROLINA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5 Social Security Number 3. 1924 **Funeral** Days Hours Months 1(XM 2□F Director 244-20-2578 80 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. The Madical Examinar must be notified at 1 ☐ Yes 2 X No MARYLAND ANNE ARUNDEL GLEN BURNIE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 102 LOUIS TERRACE 21060 21061 UNITED STATES death by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Amed Forces:

1 XYes 2 No
If Yes, Give
Year or Dates: 43-45 illed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ♥ No Specify: Specify: WHITE 3 ☐ Widowed 4 Ĭ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) SALES DISTRIBUTER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H is marked of BERTON HAYWOOD BERRY ALMA LEE JARVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health an Item 27 is 102 LOUISE TERRACE, GLEN BURNIE, MARYLAND 2106121060 MARIE B. BERRY / FORMER WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ₽ <u>=</u> 1 ☐ Butial 2 X Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) AUGUST 10 2005 permit. Page Department of Important: if any injury or once. METRO CREMATORY, INC. CATONSVILLE, MARYLAND RKLEY-RUDDICK FUNERAL HOME, P.A.
21 CRAIN HWY., SE, GLEN BURNIE, MD 21061 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stag leans Priysician 2nd disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Due to of as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner anding physicien and use as the burial-transit The law requires that the death certificate be executed peptensi Due 16 as a consequence of) P.O. Box 68760, Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 99 icate has been sig r, page 2 should b 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No 1 Yes 2X No Hospitel or Attending Physicien: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural after death, Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H44904 AUGUST 9, 2005 alled 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 304 1406B S. CRAIN HWY., GLEN BURNIE, MD 21061 LAUREN B. RICHTER, M.D. 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State AUG 1 0 2005 Registrar

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
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		1 - For State Registrer	State of	Marylan	-	rtment of H		d Mental Hy	giene	15	26068
Physici		1. Decedent's Name (First, Middle, Las Robert C. Bat	*					2. Date of D Month AUGUS	eath Day	Year	3. Time of Death 06:20A M
/Medic Examin		4a. Facility Name (If not institution, give	street and numb	per)		4b. City, Town, or PERRY PC			4c. County	of Death	00.20A
Funeral Director		Social Security Number 6. S		Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 F	fin. 8. Date of B	irth ay, Year) 22,1940	9. Birthp	place (State or Foreign ntry) LYLand
	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									
£ 5 €	Director	10e. Street and Number 17 Romanoff Cou	10f. Zip Code	21234		10g. Citizen of What Country? U.S.A.					
s after , or ita	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceded Armed Force 1 XYes 2 If Yes, Give Year or Date	^{es?} □				(Specify Yes or N Jerto Rican, etc.)		e - Americ k, White,	can Indian,
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uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Harry F. Batel	nan				18. Mother's N	Namo (First, Middle dette	e, Maiden Suman	re)	
and 2 sho ealth and I n 27 is me		19a. Informant's Name/Relationship (7 Mrs. Patricia A. 1			17 R	omanoss C		Baltimore	MD 21	234	
permit. Pages 1 and 2 Department of Health a importent: if item 27 is any injury or other tree		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		ate Cé	emetery, crem rison 1	sition (Name of atory or other place ONEST VA	8/	Date 12/2005	20c. Location - Owings N	lills	, MD
permit. Depart import any inj		21. Signature of Funeral Service Licen. Buin G. W.			9:	Name and Addres	r Rd.,	Schimunek Baltimo	r Funerai ie, MD 27	2 Hom 1236	es
Physician /Medical Examiner the private fransition and the private francs and the private francs and the private francs and the private francs and the priva	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. DIABE Due to (or Due to (or	sed the death h line. TES ME as a consequ as a consequ as a consequ	LLITUS uence of):	r the mode of dying	, such as card	alac or respiratory	arrest,		Approximate Interval Between Onset and Death UNKNOWN
The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the bur	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal t at time of de	death 3 1	Ectopic pregnancy Other (specify)			23d. Dat	e of delive	ory Day Year
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the Hosp in 24 hou the Funer	edical	29a. Certifier (Check only one) 1X Certifying Phy 2 Medical Exam	sicien: To the be iner: On the basi and manner	s of examinati	vledge, death ion and/or inve	estigation, in my op	inion, death oc	ace, and due to the ccurred at the time,	date and place, a	ind due to	the cause(s)
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0		30. Name and address of person who could JIANYI ZHANG, M.D.	,			rint)		PERRY POI		21902	
Sta Registra		31. Date filed (Month, Day, Year)	37 Reg	istrar's Signati		de)					

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Day Month **Physician** AUGUST 7,2005 9:10 F M SONJA YVONNE BROWN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 ☐ M 2**X** F 62 07/22/1943 214-40-7435 Usual Residence of Decedent Director MARYLAND 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral, or items 23e or 28e-f show Examinational be notified at 1 X Yes 2 ☐ No Director N/AMD BALTIMORE CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5357 DENMORE AVENUE 21215 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) EDUCATION/BALTIMORE and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) CITY PUBLIC SCHOOL\$ PARAPROFESSIONAL 12TH YEARS permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If Item 27 is marked othe any injury or other treumatic event, once. other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MCGEE HARRY NANNIE WRIGHT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 19a. Informant's Name/Relationship (Type, Print) 2601 MADISON AVE, APT. DERRICK T. BROWN SON #304, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS MEM PK.8/12/05 4 Donation 5 Other (Specify) ENTOMBMENT BALTIMORE CO, MD ral Service Licensee 22. Name and Address of Facility 21. Signature HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 1. 5 fler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or, or heart failure. List only one cause on each line. Immediate Cause (Final disease of condition resulting in death) **Physician** . METASTATIC LUNG CARCINOMA YEAR /Medical Due to (or as a consequence of): Examiner YEARS CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ρ 2 No 3 Probably 4 Unknown METASTASIS TO RIGHT PROXIMAL FEMUR Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SUPERIOR VENA CAVA SYNDROME autopsy performed? page 2 2 No certificate 1 Yes 2 No 1 Yes Be director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ₺ No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident I Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) npletely filled in by 4 Homicide To the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Worth, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For Stete Registra Certificate of Death Reg. No? 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Anna Elizabeth Bryant 2005 6:30 A M August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 4658 Palomino Court Ellicott City Howard If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 21XF 82 Yrs. 215-16-9265 **Director** <u> 10/21/1922</u> Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 la marked other than "natural", or Itema 23a or 28a-1 show other traumatic svent, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 1226 Spring Avenue 21237 United States death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ MNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If item 27 Ia marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lloyd Lionel Groves Anna Elizabeth Rixham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Ann Fultz/daughter 4658 Palomino Court Ellicott City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ŏ Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 8/10/05 Rosedale, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimers Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the s 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? The 2 No 1 Yes 1 Yes **3**₹ No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) daughter's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2X No 4 ☐ Nursing Home 5 ☐ Residence 6 反 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 XCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 H005Z365 August 9, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald Jeffreys 4801 Dorsey Hall Drive Suite 201 Ellicott City, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Elecus & Goarle DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otato of Mary	Ce	ertificate of	Death		Reg. No. 2	05 2	6071
	Dharaisi		1. Decedent's Name (First, Middle, Las					2. Date of De	ath	3.	lime of Death
	Physici /Medio		Stephen Harry					August			0:00 AM
	Examir	er	4a. Facility Name (If not institution, give 8 Perhall Court	street and number)			4b. City, Town, or L Baltimo	re	Balt	imore	
	Funeral Director	213-32-1602 14 67 4rs. Sept. 25, 1937 Maryl									State or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. In	side City Limits
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	or 284	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	/hat Country?	
Baltimore, Maryland 21215-0020	ath wi	ral	8 Perhall Court			212				S.A.	
	in 72 hours efter death with the Maryland "natural", or items 23a or 28e-f show ledical Examinat mart be rotified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	r in U,S. 13.	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🂢 No		pecify Yes or No o Rican, etc.)	Blac	e - American Ind k, White, etc. : White	dian,
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Ba	permit. Pag Depertment Important: I any injury o		21. Signature Funeral Service Licen	See		9705 Beld					1236
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the one ceuse on each line.	death. Do not er	nter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Inter	oximate val Between et and Death
	Physician /Medical		Immediate Cause (Final	1.000	. /	b 11 a	4			Orise	and Death
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B	thet the death ce ed by the ettend detached for us	Physician/	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the	underlying cause giv	ven in Part I.	23b. Did	tobacco usa cor	tributa to tha	cause of death?
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0	ng Ph fter th ineral		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time Injury	Wor		28d. Describe	how injury occurr	ed	
sio	Attending I er death. rector: After by the funer	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		At home form		Yes 2 □ No	29f Location /	Street and Number	ar or Pural Pou	te Number
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	To the Hospital or Attending Phwithin 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	edical C		ysician: To the best of my niner: On the basis of exa and manner stated.	mination and/or in						eause(s)
	To the within 2 To the comple	Me	26b. Signature and title of certifier	0		29c. Licens	se number		29d. Date signed	(Month, Day,	Year)
			1 Town Edw	non los	~ MI	n D4.	5766		Angust	8 20	0.5
1	0		30. Name and address of person who	completed cause of death			D 0	7. · · ·	August Himore	,	2 /2 2 7
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Tanklin Signature	Square	Dr., He.	512, Ba	Monore	MP	+125/
	Registr	ar	AUG 1 0 20	05 Status	15 /						

DHMH 16 Rav 6/95

Alexander T. Bostick, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-05264 State of Maryland / Department of Health and Mental Hygiene crn Reg. No.2 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2005 7:48 August T. Bostick Alexander /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facifity Name (If not institution, give street and number) Examiner Baltimore Overlea 7200 Beech Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**□**M 2□ F 61 Yrs. Sept41943 Director 215-40-7664 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Item 27 Is marked other then "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercises could be publised at Once. 1 Yes 2 □ No Directo MD Baltimore Overlea 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7200 Beech 21206 U.S.A. Funeral Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth Taxi Driver Yellow Cab Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alexander Bostick Cora Lee McNeill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Beech Ave. Balto. Md 21206 Hilton Bostick/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GreenMount CemeteryAugl0,2005 Balto., Md 21. Signature of Puneral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) computating Atheroscleratio attyperthermia **Physician** /Medical Due to (or as a consequence of) Cardiovasculous Duscase Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): physician er s the burial-t Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an page 2 autopsy performed? this certificate 2 □ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Impatient 2 | ER/Outpatient 3 | DOA Other 4 Nursing Home 5 Residence 6 Nother (Specify) at scene 1∭XYes 2☐ No After this c ပ္ 28a. Date of Injury
(Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred
Subject exposed to elevated
Environmental temperature 28c. Injury at Work? 27. Manner of Death Certification; 1 Natural 5 Pending 1 Yes 2 No death. 2 Accident 3 Suicide investigation within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 7200 Beech NC BOLL TOWN/E JUDI 4 - Homicide Resdence Baltrivore Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

11

31. Date fifed (Month, Day, Year) 3

AUG 1 0 2005

30. Name and address of person who completed cause of death, (ftem 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

August 05, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Negistre AMEND ITEM #26 per verb g846 9911/6/1950 gf Death Reg. Ne. U 0 5 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 200 tuqusi /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner uepoint Center 9. Birthplace (State or Foreign 7. Age (In yrs. iast birthday) 42 Yrs. 8. Date of Birth Month, Day, **Funeral** Months Days 66-260 1 □ M 2 F Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show me 23a or 28e-f shortment to 1 Yes 2 □ No Be Completed by Funeral Director Maryland more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status other traumatic event, the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life._DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ren ၀ Soute Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Number of Rural t of Health Moreland 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition Green Mount Crematery 22. Name and Address of Felity or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ŏ 2005 Department 21. Signature of Funeral Service Licente 23a. Part Enter the dilease, or complications that usused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shot, or heart in ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HRONC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 Z No. Day 4 Pregnant at time of death 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signer Division of Vital Records, 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 1 ☐ Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one Hersing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation I Director: / 28f. Location (Street and Number or Rural Route Number. City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours aff To the Funeral DI completely filled in the Hospitel 29a. Curtifiar entifying Physician: To the best of my knowledge, death decimed at the time, date and place, and due to the cause(s) and manner as stated. Centifying Physician: To the best of my knowledge, seath secured at the time, date and place, and due to the cause of the (Check only one) 29c. Ocense number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier beit who completed cause of death (Item 23a) (Type, Print)

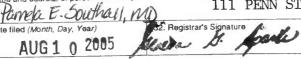
State Registrar HEIGH.

PARIC

31. Date filed (Moorth, Pay, Year) AUG 1 0 2005

32 Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year) 2005 0



AU.	REHKEND		1 - State Unpend Item Registrar	State of Ma 23a, 27, 28a	aryland/De -f per me	partment of l G846 8-1 entificate of	lealth and 1-05 tas Death	Mental Hyg	iene	06075
	Physici	an	Decedent's Name (First, Middle, I ALAN		BEHREN			2. Date of Dea Month	th ZUUJ Day Year	3 Pinte of Death
2	/Media	al	4a. Facility Name (If not institution, g		DETINE	-	or Location of Dea	AUGUST	06, 2005 4c. County of Dea	18:13 [™]
	Examir	er	11324 Park Heigh			Owings	Mills		Balt	imore
5	Funeral Director		5. Social Security Number 6 220-46-5300	Sex 7. Ag	e (In yrs. last birthda 48 Yrs.		If Under 24 Hi			rthplace (State or Foreign ountry)
9	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	the Marylan 28a-f show	ō	MD N/	Λ		TIMORE				1 V Yes 2 □ No
	the M	Director	10e. Street and Number	<u> </u>	DAL	10f. Zip Code		1	0g. Citizen of What C	
	deeth with the Maryland ms 23a or 28a-f show rmust be notified at		6722 WESTBROOK	ROAD			21215			USA
36	rs after deet I', or items 'xaminar mu	by Funeral	11. Marital Status 1 Mover Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1	Ever in U.S. 13	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☒ No		(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:	
8	72 hours "naturel", idical Ex		15. Decedent's	Education	16a. De	cedent's Usual Occu	pation	- 4:	16b. Kind of Busines	s/Industry
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þ	e filed al Hygie other vent, li	BeC	17. Father's Name (First, Middle, La	st)			18. Mother's N	ame (First, Middle, i	Maiden Sumame)	
ylaı		To	ALAN EDWARD		HREND,	SR.	AUDHF		. O: T C4-4-	WRIGHT
Mar	ges 1 and 2 should t of Health and Mer if item 27 is marks or other traumatic		19a. Informant's Name/Relationship ALAN E. BEHREN						RE, MD 21:	
	es 1 and 2 of Health filem 27 rother tra		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pla			20c. Location - City o	
<u>=</u>	Pege ment c ant: if ury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		BALTIMOR	E HEBREW			REISTERS	· · · · · · · · · · · · · · · · · · ·
Baltimore,	permit. Peg Depertment Important: i any injury o		21. Signature of Funeral Service Lic	ensee /		22. Name and Addr			ON & BROSPIKESVILLE	
25.			23a. Part / Enter the disease, or co shock, or heart failure. List of	prolications that caused by one cause on each li	the death. Do not ene.	enter the mode of dy	ng, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
100	Physician /Medical	V.	Immediate Cause (Final disease or condition resulting in death)	_ a	Due To I	nhalation	Of Car	Exhaust		
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8760,	ate be execute hysicien and the burial-trans	dical		d						
9		Medi	IF FEMALE:			-				
). Box	The law requires thet the death certific tre has been signed by the attending p bage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	B Ectopic pregnand D Other (specify)	<u>-</u>		23d. Date of do Month	olivery Day Year
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Ö	itel or A rs after rel Dire led in b	Cert	Tomos	Scene	c. (Specify)			Ave., Ow	ings Mills	s, Md
	To the Hospitel or within 24 hours after To the Funeral Discompletely filled in	edlcal	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	f examination and/or	ath occurred at the t investigation, in my	me, date and pla opinion, death oc	ce, and due to the co	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	Vith Com	Σ	29b. Signature and title of certifier			29c. Licen	se number		9d. Date signed (Mor	
	1		Yanut Jou	thall, MD		21.11	O.C.M.E	•	August 07,	2005
4	order	γ	6. Name and address of person with the same of the sam	o completed cause of courthall, M	leath (Item 23a) (Typ		eet, Bal	timore. M	aryland 21	201
1	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature		,			
	Registi	ar 🏻	AUG 1	0 2005	ener It	book				

CPM 05-05320 Calvin Cofield

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

		4	For State Ragistrar	State of M	aryland /		tificate of L		F	leg. NO.	05	26076
8	Physicia	n	1. Decedent's Name (First, Middle, L.						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al -	Calvin		ield		4h Cihi Toum or	Location of Death	August		2005 nty ol Death	01:28 A M
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	\$ 1				e (In yrs. last i		II Under 1 Year	If Under 24 Hrs.	8. Date of Birt	_		place (State or Foreign intry)
\$	Funeral Director			· 5344 00 5	2	Yrs.	Months Days	Hours Min.	Nov. 17	, 1982	Mar	yland
	iand ow		10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Mary I-f ah	to	Maryland Prince G	eorge's		La	irgo					1 ☐ Yes 2 🎇 No
	death with the Maryland ima 23a or 28a-f a how r must be notified at	Funeral Directo	10e. Street and Number 1507 Kemper Ct	•			10f. Zip Code	20772		10g. Citizen o	U.S.	
Maryland 21215-0036	ours after al', or its Executor	þ	11. Marital Status 1 (XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:		1	Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No- p Rican, etc.)	Spe		can American
5-0	72 hours "natural", uicsi Ex	etec	15. Decedent's ((Specify only highest g	Education rade completed)	16	Sa. Deced (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of	Business/li	ndustry
121	C	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		andscaper			Nurse	rv	
d 2	Hygie than than	ပိ	17. Father's Name (First, Middle, Las	it)			andscaper	18. Mother's Nan	ne (First, Middle,			
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ary	shou and M a mar		19a. Informant's Name/Relationship				ng Address (Street					ip Code)
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Baltimore,	Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. Int: If Item 27 is marked other than ity or other treumatic event, Item.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			Crem	esition (Name of matory or other place atory	2005	Sate 9,		on, M	aryland
Balti	permit. Pages Department of Important: If I any Injury or 2005.	Ì	21. Signature of Funeral Septice Lic	9 (00357		Name and Address 01d					on, MD20735
. 79	No.		29a. Part1. Enter the disease, or co shock, or heart lailure. List on			o not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 175A		SUR	•		-			Onset and Death
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rds	quires n sign uld be	d by							1 🗆 '	res 2 No	3 □ Pro	bably 4 Unknown
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ĭŽ	or Att ter de irecto	rific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Ir building.	njury - At home atc. (Specify)	, farm, st	reet, factory, office		28l. Location (Street and Nu wn, State)	imber or Ru	ral Route Number, MV
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	To the Hospitel or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fi	edical Certification:	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examination	and/or in	in occurred at the th	opinion, death occu	urred at the time,	date and place	ce, and due	to the cause(s)
	vithin To the	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date sig	ned (Monti	n. Day. Year)
	, , , , , , , ,		> Mayure 1	ne Maile	hm		(O.C.M.E.		Augu	st 07	, 2005
4			30. Name and address of person when the same and address of person when the same and the same an	no completed cause of	death (Item 23	111	Print) Penn Stre	eet, Balt	imore,	Maryla	nd 212	201
	Sta	te	31. Date liled (Month, Day, Year)	32. Regis		9	1 4.					
1	Regist		AUG	1 0 2005	Mague	J.	foods					

			Amend Item 7&8 p	State of Marylar	nd / Departme	nt of Health and	Mental Hy	giene		
			Amend Item /&8 p	er in Go40 o-1	Certifica	te of Death			5 26	077
	Dhysisi		1. Decedent's Name (First, Middle, La	st)			2. Date of Dea Month	Day	Year 3. Tir	ne of Death
н	Physici /Medio		Beverly pa	niels			August	8 20		3:20
Sec. Comments	Examir		4a Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	r Location of Death	4c. County	of Death	
1			Johns Hopkins	Bay view M	redical cer	ner Baltin	nore	7-13-10	X/A	
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs. □ M 2 1 F 44	. last birthday) If Und Months	er 1 Year If Under 24 Hr Days Hours Mir	8. Date of Birt (Month, Da	7-13-19 V, Year)	Country)	tate or Foreign
	Dírector		2\1 - 76 -2666 Usual Residence of Decedent	44	113.		0-1/13	/1960 1	vorin Ca	rolina
	and and		10a. State 10b. County	10c. Ci	ity, Town or Location				10d. Insi	de City Limits
	Mary	ō	Mariland N/ +		Raltim	ore			15/2	Yes 2□No
	the 28s	Je C	10e. Street and Number			ip Code		10g. Citizen of W	hat Country?	
	3a o	₫	2219 Wind	Sor Ava		21216		U	SA	
	72 hours efter death with the Maryland natural', or Items 23s or 28s-f show dical Evaniner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in L	J.S. 13. Was Dec	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	Specify Yes or No	14. Race	- American India	an,
0	or Ite		1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 No If Yes, Give	1 ☐ Yes		into Alcan, etc.)	Specify	-1	17
21215-0020	rall, o	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				Specify.	Blac	K
5	72 hours natural',	etec	15. Decedent's Ed (Specify only highest gra	lucation de co <i>mpleted)</i>	16a. Decedent's Us (Give kind of w	ual Occupation ork done during most of w use retired)	orking	16b. Kind of Bu	siness/Industry	
2	within iene.	g	Elementary/Secondary (0-12)	College (1-4or 5+)	0	i i		Hank	11 0	~
2			17. Father's Name (First, Middle, Last,		Sect	etary	ame (First, Middle,	Maiden Surnam	in Ca	16
ano	e a a b	Be	Trainers Name (First, Middle, Last,	ald Dan	1010	000	Δ .	0000		
Maryland	should by nd Menta marked imarked	ا	LITIES FIGU	DICI DOLL	19h Mailing Addre	ss (Street and Number or F	Bure Boute Number	or City or Town	State. Zip Code)	
Ma	C1 0 20 21		19a. Informant's Name/Relationship (GHOINEL	ITANE	ss (Street and Number or F	ALIOA	Pt. Bu	Ho MA	21223
	s 1 and if Health item 27 other tr		20a. Method of Disposition	Daniels	Place of Disposition (N	ame of	Date	20c. Location -	City or Town, Sta	
ğ	g = 2		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crematory or	other place)	8/13/2005	Lanc	downe,	MA
altimore,			4 ☐ Donation 5 ☐ Other (Specifical Service Licer)		22 Name:	and Address of Facility	1-12005	RUIS	iowne,	/41a.
Ba	permit. Depertmitmoportal any Inju		1010	V D	Josep	h L. Russ	Funera	Home	P.A.	
		\vdash	23a. Part J. Enter the disease, or com	That agreed the dea	th Do not enter the my	W. North	ac or respiratory as	uto. (Yld	. 21 21 k	ximate
	Discrete to the		23a. Part 1. Enter the disease, or com shock or heart failule. List only	one cause on each line.	an. Do not onto the m	, do 0, dyg, 000 20 02d.		,	Interva	al B <i>e</i> tween and Death
	Physician /Medical		Immediate Cause (Final		•.				1	
	Examiner		disease or condition resulting in death)	a. Acute Rend	or as a consequence of	·)·			!	
		Je								
	icete be executed physician and s the burial-transit	Examiner	Sequentially list conditions.	b. Metastatic	or as a consequence of				· ·	
O O	e exe ian a urial-t		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						1	
68760,	hysic the b	lcal	that initiated events resulting in death) Last	Due to (c	or as a consequence of):				
		Med		d.						
Вох	denth certifi e Ettending ed for use as	Physician/M		V.						
P.0.	y the stacked	ysic	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	cause given in Part I.		obacco use con		
	g 8 g	돈	AIDS				1년 -	Yes 2∐ No	3 Probably	4 Unknown
ds	sign d be	d by						an autopsy	24b. Were auto	
Ö	law requires as been sign s 2 should be	ete					perfo	rmed?	available propertions of death?	n of cause
Re	9 - 6	Completed					4776	00 21/10	1 ☐ Yes	2□ No
of Vital Records,	l cie n: Th certificate rector, pa	0	25. Was case referred to medical			26. Place of D	eath (Check only o	nel		
5		To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 (OOA Other: 4 Nursing	Home 5 ☐ Resid	dence 6 □Othe	or (Specify)	
0			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe I	now injury occurr	ed	
Ö	Attending In death.	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1	M	1 ☐ Yes 2 ☐ No				
Division	or Attend efter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factority)	ory, office	28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural Route	Number,
	ital or is efter al Dir led in		,							
	To the Hospital or Attent within 24 hours efter deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 ♥ Certifying Ph (Check only one) 2 ■ Medical Exar	yaidan: To the best of my kno niner: On the basis of examina	owledge, death occurre ation and/or investigation	d at the time, date and placen, in my opinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the ca	use(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.	2	9c. License number		29d. Date signed	(Month, Day, Yo	ear)
	₹ ¥ ₽ 8	8.	(01010)	ak.a		RES - 00		ugust	8 20	05
),	1/		30. Name and address of person who	completed cause of death /fte	m 23a) (Type, Print)	LEG - 00		109031	0 20	
	C'		Anne Tuskey			ayview meo	lical c	enter	-	
	Sta	te.	31. Date filed (Month, Day, Year) 2	005 32/Registrar's Sign		1.10				
	Registr				1					

		State of Maryland / Department of Health and M	lental Hygi	
		1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of Death	
Physicia /Medic		DORIS LEOLA EVANS	August	6 205 11:48 PM
Examin	er	4a. Facility Name (If not institution, give street and number) BALTIMORE WASHINGTON MEDICAL CENTER 4b. City, Town, or Location of Death GLEN BURNIE		46. County of Death ANNE ARUNDEL COUNTY
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday)	8. Date of Birth (Month, Day March I	9. Birthplace (State or Foreign Mary Land
land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Ba-f eh	ctor	Md. Anne Arundel Co. Pasadena		1 ☐ Yes 27 No
death with the Maryland ms 23a or 28a-f show	Completed by Funeral Director	10e. Street and Number 100 Hastings Lane	10	og. Citizen of What Country? U.S.A.
Items :	Funer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Marned 1 Yes 217 No 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
0036	d by	3 M Widowed 4 □ Divorced If Yes, Give 1 1 □ Yes 2 No Specify:		Specify: White
21215-0036 21215-0036 giene. or then "netural", or	piete	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker	ing	Own Home
ind 21 Hygien other the ent, Its	Be Con	17. Father's Name (First, Middle, Last) 18. Mother's Name		faiden Sumame)
Maryland d 2 should be file lith and Mental Hy 27 is marked oth treumatic event	To B	John Palmer Hamlin Violet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run.	Fe:	
, Mai		Cory J. Evans (Son) 100 Hastings Lane, Page	sadena, l	Md. 21122
nore ages 1: ont of He t: If iten		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Pk.08/	110	Coc. Location - City or Town, State
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Martal Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-1 ehow any injury or other treumatic event, the Madical Examinet must be notified at once.		21. Signature of Eureral Service Licensee 22. Name and Address of Facility MCCully-Polynia 237 E. Patapsco		
		23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	st, Approximate Interval Between Oกุรet and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):		Hours
Examiner	10	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):		Hours
cuted	Examiner	cause. Liner Unionlying Cause (Disease or injury that initiated events c. Hyperchole Herolemo		Horths
Box 68760, eath certificate be executed attending physician and for use as the burial-transit	cal Ex	resulting in death) Last Due to or 's a consequence of): d.		23.2
68°.		IF FEMALE:		
. 0 00	Physician/Med	23b. Was decedent pregnant in the past 12 poinths? 1 \(\text{Yes} \) 2 \(\text{No} \) No 9 \(\text{Unknown} \) Unknown		23d. Date of delivery Month Day Year
rds, P.O. quires that the n signed by the	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to the cause of death?
Division of Vital Records, to Attending Physicien: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be control to the funeral director.	Completed		24a. Was ar autopsy perform 1 Yes 2	prior to completion of cause of
of Vita Physicien: this certific	Be	25. Was case referred to medical examiner? Hospital: 1 Compared to Management of the Compared t		
on of Jing Phys	on: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work?	28d. Describe ho	nce 6 Other (Specify) w injury occurred
Division of Vital Re To the Hospital or Attending Physicien: The Wilhin 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town	eet and Number or Rural Route Number, State)
Hospitel 4 hours a Funeral filled	edicai Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated. Additional control of the desired from the de	and due to the ca red at the time, da	use(s) and manner as stated. Ite and place, and due to the cause(s)
To the within 2 To the complete	Med	29b. Signature and title of certifier 29c. License number	29	od. Date signed (Month, Day, Year)
1200		MUU AUU MD DOO 3274 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)	4 1	tugust 4, 2005
L		MARIA GAVIRIA MD 301 Hospital Dr Glen	Burni	e MD 21061
Sta Registr		31. Date filed (Month, Day, Year) AUG 1 0 20 05		

			For State Registrar	State of	Marylan		artment			ınd M	ental Hyg	iene •9. N 2. ()	N 5	26079
			Decedent's Name (First, Middle)	Last)							2. Date of Deal		Year	3. Time of Death
	Physicia /Medic	al	Shurley	ternell	Eas	Jer	4b. City, To		Location	f Doath	8	8 46 Cour	2005 nty of Death	10:40а м
	Examin	er	4a. Facility Name (If not institution Longgreen I		iber)				more.			40. 0001	N A	
	Funeral Director		5. Social Security Number 243–46–8692		7. Age (In yrs. 71	last birthday) Yrs.	If Under 1 Months I	Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day) 1-28-	, Year)	9. Birthp Coun	lace (State or Foreign try) N.C.
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	Maryis f sho	tor	Md.	N A			Baltim	ore						1 XYes 2 ☐ No
	or 28a	Director	10e. Street and Number				10f. Zip C				1		of What Coun	itry?
	s 23a		1302 N. Penr	nsylvania 12. Was Dece		S 13 1	Was Deceder		21217		city Yes or No-	US 14. B	A Race - Americ	an Indian.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. itam 27 Is marked other than "natural", or Itams 23e or 28e-f show other traumatic event, the Marylast Ever it art must be metified at	by Funerai	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed For	ces? 2 [X No e		If Yes, specify		Specify:	, Puerto	cify Yes or No- Rican, etc.)		Black, White,	
21215-0036	72 hou natura	eted	15. Decedent (Specify only highes	's Education t grade completed)		(Give	dent's Usual (done d	uring most	of worki	ng	16b. Kind of	f Business/Inc	dustry
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT use staura)			Mar	riott S	Sky King
d 2	illed with Hygiene other the	Be Co	8th grade 17. Father's Name (First, Middle,	Last)			DCG 02 G		18. Mothe		(First, Middle,		name)	
Maryland	should be nd Mental marked o	To B	Charlie		В	own				Olli				iter
Mar	d 2 sho th and 7 Is mu traum	ı	19a. Informant's Name/Relations Sidney Easte		sband						i Route Numbei lay, Ow			Code) 21117 M.d.
	s 1 and 2 f Health itam 27 l		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name	e of	1				on - City or To	
e i			1 Burial 2 □ Cremation '4 □ Donation 5 □ Other (S		State	oshell				8-1	2-05	Dun	dalk,	Md
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service	Licensee W c	men		2. Name and March						th Av	21202 7e.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that controls one cause on e	aused the deat ach line.	h. Do not en	ter the mode	of dying	g, such as	cardiac o	or respiratory arr	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	or as a consec	Ca	ncer							Lyears
	Examiner			b	or as a compac	erice or).								•
	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as a consec	juence of):								
	xecute and al-trans	Examiner	that initiated events resulting in death) Last	c	or as a consec	uence of):								
760,	e be e /sician e buria	caiE		d										
9	artificat ing phy e as th		IF FEMALE:							7.6				
О. Вох	that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of c	al death 3[⊒Ectopic pred ⊒ Other <i>(spe</i> d			-			Date of delive Month	ory Day Year
S, P	es gr	by	Part II. Other significant condition Adult Weet	Debe	eath but not res	sulting in the c	inderlying cau	use give	en in Part I		23e. Did to			he cause of death?
Record	law requir as been si 2 should	Completed	thertens	in							24a. Was a autop	sy	prior to co	psy lindings available mpletion of cause of
al R			COPD									2 No	death? 1 Yes	2 No
Vital	Physician: this certificant all director.	o Be	25. Was case re erred to medica examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	Hospital:	npatient 2] ER/Outpatie	nt 3 DOA	Othe		of Death	n <i>(Check only or</i> me 5 ☐ Resid		Other (Specif	(y)
n of	ding Phy n. After this funeral o	Ju: T	27. Manner of Death 1 Natural 5 Pendir	28a. Date	of Injury th, Day Year)	28b. Time o		c. Injury			28d. Describe h			
Division	Attending r death. ector: After by the fune	icatio	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	gation not be	of Injury - At h	omo form of	M root factory		Yes 2□	-	28L Location /S	treet and Nu	imber or Run	al Route Number,
Divi	after death Director:	Certification:	4 ☐ Homicide determ	ined 28e. Place buildi	ng, etc. (Speci	fy)	теві, іасіоту,	ONICE			City or Tow	m, State)	impor or rigit	
-	To the Hospital or Attending Physician: within 24 hours after death. To tha Funaral Director: After this certific completely filled in by the funeral director.	Medical C		ig Physician: To the Examiner: On the b and man										
	To the within To the compl	Me	29b. Signature and title of certific	11.1	Λ		29c.	License	e number			29d. Date sig	gned (Month,	Day, Year)
	10		Mille	Math	tone	J.M.	1	141	66	5		8-	105	
1	/ /		30. Name and address of person	who completed claus	e of peath (Ite	m 23a) (Type	Print)	Pau	2	PCa	ce Ste	420	Bell	LUD ZIEWZ
	Sta	ate	31. Date liled (Month, Day, Year,	32. R	egistrar's Sign	ature 🧎	A CONTRACTOR OF THE PARTY OF TH	29					<u>`</u>	
	Regist	rar	AVu	7 0 5000	Literape.		1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 2. Oate of Death 1. Decedent's Name (First, Middle, Last) MOUGUST Days, 2005 **Physician** 12:42P M Dorothy Ferenschak Christina /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Center OWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
April 1, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 21 F Months 81 Yrs 1924 Pennsulvania 203-16-0710 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or itams 23e or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Nottinaham Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 U.S.A. 4226 Darleigh Road 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Int: If itam 27 is marked of Joseph Kradjel Thresa Wuka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frederick A. Ferenschak (husband) 4226 Darleigh Road, Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Joseph Church Cemi 8/12/05 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hart failure. List only one cause on each line.

Immediate Cause (Final disease or condition 9705 Belair Rd., Baltimore, MD 21236 Approximate Interval Between Onset and Death YEARS CRITICAL AORTIC STENOSIS END INSUFFICIENCY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ACUTE PULMONARY HEMORRHAGE HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit HOURS requires that the death certificate be executed ACUTE THROMBOTIC PROCESS Due to (or as a consequence of): HOURS BLEEDING FROM RIGHT VENTRICLE Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 2 No 2/1 No 1 Yes Hospital or Attanding Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 N Other: 4 Nursing Home 1 Inpatient 2 □ No 2 ER/Outpatient 3 DOA 2 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 To tha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D38570

State

JEFFREY SELL

DRIVE TOWSON, MARYLAND 21204 7601 OSLER 32. Registrar's Signature

31. Date filed (Month, Day, Year) 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			1 - For State Registrar	State o	f Maryl	•	artment of H rtificate of I	lealth and M Death		giene Reg. NQ. () () [2001
			Decedent's Name (First, Midd	le, Last)					2. Date of Dea	ath C. U.	10-	3. Time of Seath
	Physicia /Medic		Mary	Flet	cher				August		Year 2005	5:45 P M
	Examin		4a. Facility Name (If not institution 1027 SUMTER	. •	mber)			Location of Death		4c. County	of Death BALTT	MORE
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	h		lace (State or Foreign try)
	Director		212-70-2063	1 ☐ M 2 🖫 F		86 Yrs.	Months Days	Hours Min.	(Month, Da) 3-15-1	919	MAR	YLAND
	and w	}	Usual Residence of Decedent 10a. State 10b. County	,	10c	: City, Town or Lo	cation				1	Od. Inside City Limits
	ith the Marylan or 28a-f ehow	tor	MD B	ALTIMORE			RO	SEDALE				1 ☐ Yes 2 🎇 No
	or 28;	Jirec	10e. Street and Number				10f. Zip Code			10g. Citizen of \	What Coun	itry?
	ath w	rai		R AVENUE				21237			U.S.A	
	ter de	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma	12. Was Dec Armed Fo rried 1 ☐ Yes	rces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Blac	e - Americ ck, White,	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If tiern 27 is marked other than "natural", or items 23a or 28a-f show important: If tiern 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantical must be notified at once.	þ	3 ₩Widowed 4 Divorce	If Yes. Gi	VA T		1 □ Yes 2 🔀 No	Specify:	5	Specify	WHI	TE
2	"natu	letec		nt's Education est grade completed)		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work	ring	16b. Kind of B	usiness/Ind	dustry
7	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	IOMEMAKER	,		(H NWC	OME
ם ס	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle					18. Mother's Nam	e (First, Middle,			
ylar	Menta Menta arked atic e	ToE	EMORY	JOHNS	SON			MARY			OORE)	
Mar	12 sho		19a. Informant's Name/Relation					and Number or Rur				
e,	1 and Healt tem 2		T. GORDON FLE 20a. Method of Disposition	TCHER/ SON			SUMTER A esition (Name of matory or other place		ROSEDA Date	ALE, MD 20c. Location -		wn, State
Ē	Pages lent of nt: If i		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (State		OF FAITH	š .	-2005	BALTI	WORE.	MO
<u>=</u>	permit. Departm Importa any inju		21. Signature of Funeral Service			and the second second	2. Name and Addres		ACH/ROSI			
מ	205 29	- 27						ACO AVENU		SEDALE,	MD	21237 Approximate
			23a. Part1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final	t only one cause on	each line.	DO HOT BIT) CI	or respiratory ar	1631,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to	(or as a cor	nsequence of):	VEN	100				
	Examiner		Sequentially list conditions.	b	F	Zanc	teut)	C Ce	arcir	OMO	1	
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a côr	nsequence of):					11	
•	al-trar	Examin	that initiated events resulting in death) Last	c. Due to	(or as a cor	nsequence of):					-	
09/80	ficate be executed physician and st the burial-transit	edicai										
	** On or		IF FEMALE:	00. 16						Ι		
X D	The law requires that the death certi- lie has been signed by the attending sage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?			Fetal death 3	Ectopic pregnancy Other (specify)	1			te of delive onth	Day Year
j.	t the d by the	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn								
, L	es tha igned be del	by P	Part II. Other significant condit	ions contributing to d	eath but no	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	_		ne cause of death?
0.00	requi	eted	01100		77	1/105	10/10/	DKOMSE	, .	T		
vital Records,	helaw hasb	Completed	HTOL	DXA	OLIC		2NUC	DIGUIT	24a. Was autop	rmed?	death?	psy findings available mpletion of cause of
<u>a</u>	an: T	0	25. Was case referred to medic	al				26. Place of Deat	1 ☐ Yes		1 🗆 Yes	2 No
0 0	hysici nis cer I direc	To B	examiner? 1 🗌 Yes 2 🔁 No	Hospital: 1 🗆	Inpatient	2 ER/Outpatier	nt 3□ DOA Oth	er: 4 🗆 Nursing Ho	ome 5 Resid	dence 6 🗆 Oth	er (Specif	γ)
חכ	ling P	lon:	27. Manner of Death Natural 5 Pend	"'9	of Injury oth, Day Yea	ar) 28b. Time o	Wor	yat k? Yes 2 □ No	28d. Describe h	now injury occur	red	
UIVISION	Attence death ctor:	ertification;	3 ☐ Suicide 6 ☐ Could	mined 286. Place	of Injury -	At home, farm, str	reet, factory, office	163 2 110			er or Rura	l Route Number,
5	s after al Dire	Cert	4 Homicide deter	build	ing, etc. (S)	pecify)			City or Tow	vn, State)		
	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director adther this certificate has completely filled in by the funeral director, page 2.	Medical		ing Physician: To the I Examiner: On the band man								
	To the within To the comple	Me	29b. Signature and title of certifi		11 8	\	29c. Licens			29d. Date signe	d (Month,	Day, Year)
			1 200	a upo comploid	on ol don't	(Itom 22a) (Time		3888		818	120	505
1	U		30. Name and address of person	Talib.	W. I) 1 82	7 Linden	Avenue	Bult	incre 1	YD,	21201
	Sta Registr		31. Date filed (Month, Day, Yea AUG 1		gistrar's S	Signature	barde	,				
				4	- ALLENS		4 5 5 5 5					

	-	State of Maryland / Department of Health and Men State of Maryland / Department of Health and Men Certificate of Death	nai mygien Reg. N	
		Decedent's Name (First Middle Last)	Date of Death	CUUS G. Time of Belat
Physicia		Elizabeth Ann Frist	Month D	2005 1:15 A
/Medic Examin		ia. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4	c. County of Death
		FRANKLIN SQUARE HOSPITAL CENTER ROSEDALE		BALTIMORE
Funeral Director		Months Dave Hours Min	Date of Birth (Month, Day, Yea MCh 2, 1	9. Birthplace (State or For Country) 945 Maryland
pung M		Usual Residence of Decedent 10c. City, Town or Location 10c.		10d. Inside City Lin
with the Maryland e or 28a-f show the rectified at	Po	Maryland Baltimore White Marsh		1 ☐ Yes 2 🗓
the 28a-	rect	10e. Street and Number 10f. Zip Code	10g. (Citizen of What Country?
3e or	0	5407 Bush Street 21162		u.s.A.
ges 1 and 2 should be filed within 72 hours after death with the Marylan to fleath and 2 should be tiled within 72 hours after 30 or 28a-f show if them 27 is marked other than "naturel", or iteme 23e or 28a-f show or other traumatic event, the Mcdical Exameration to citied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Specify: 1 Yes 2 No Specify:	/ Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: Il tem 27 is marked other than "naturel", or any injury or other traumatic event, the Medical Examples.	Completed t	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/Industry
withii lene. than	dwo	Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) 06fice Manager	F	Roofing
filed Hygid other	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name (F		en Sumame)
Aental Aental rked c	To B	Steet beeg W. Hoteline to	Lackl	
2 should be and Mental I s marked or raumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural R		
and and a salth n 27		Bernard G. Frist, Sr. (husband) 5407 Bush Street, White		MD 21162 Location - City or Town, State
of He		20a. Method of Disposition cemetery, crematory or other place)		
Pages Iment of tant: If It jury or o		1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sign June 1 Fin ral Sovice Licenses 22. Name and Address of Facility Schur		
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai		9705 Belair Rd., Bal	timore,	
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respectively. Instead of the death of dying, such as cardiac or respectively. Instead of the death of dying, such as cardiac or respectively. Instead of dying, such as cardiac or respectively.		Interval Betwee Onset and Dea
icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b		
eath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Yea
ires that the signed by	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of dea
or Attending Physicien: The law requires that the dater death. Director: After this certificate has been signed by the fin by the tuneral director, page 2 should be detached	Completed		24a. Was an autopsy performed 1 Yes 2 💢	24b. Were autopsy findings ava prior to completion of caus death? No 1 Yes 2 No
ician: Th	Be C	25. Was case referred to medical examiner?	Check only one	
hysician: this certific al director,	L OF	1 ☐ Yes 2 💢 No Hospital: 1 💢 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Output 4 ☐ Nursing Home		e 6 ☐Other (Specify)
nding Ph ath. r: After th		27. Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation (Month, Day Year) M 1 Yes 2 No	d. Describe how i	
el or Attendi s after death. I Director: A	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Stree City or Town, S	t and Number or Rural Route Number State)
To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the tu	ledical C	29a. Certifier (Check only one) 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the caus t at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day, Year)
	/	H0025057		8/8/05
1 /		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	_	Ds. Britimore MD

		•	1 - For State Registrar	State of Mary		artment of I			giene Reg. N2 0 0 5	5 26083
	Dhysiai		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath	3. Time of Death
	Physici /Medic	al	Donald L 4a. Facility Name (If not institution, give s	eroy Foland	<u> </u>	4h City Town	or Location of Deatl	August	4, 2005	4:20 AM M
	Examin	er	214 A East Sixth				lerick	,	Frede	
	Funeral Director		5. Social Security Number 6. Sex 220-34-0615	M 2□F 7. Age (In 66	yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Day Dec. 3	, Year, 9. 1938 M	Birthptace (State or Foreign Country) aryland
	and and		Usuaf Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl a-f sho	tor	Maryland Frederic	K	Frederi	ck				12 Yes 2 No
	th with the 23a or 28a	al Director	10e. Street and Number 214 A East Sixth	Street		10f. Zip Code 21	701		10g. Citizen of Wha	t Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If Itam 27 Ia marked other then "netural", or Itama 23a or 28a-f show any injury or othar treumatic avant, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1XXVes 2 No ff Yes, Give 1961- Year or Dates:	1963	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2☐∭No	Hispanic Origin? (S pan, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	- 14. Race - / Black, V Specify:	American Indian, Vhite, etc. White
21215-0036	"natur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Busin	ess/Industry
121	l withir iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		umber	,,,		Plumbin	g Contractor
g	al Hyg d otha	BeC	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
Maryland	hould to d Ment marker matic	ို	Roger Herbert 19a. Informant's Name/Relationship (Type		19b. Mailin	ng Address (Street		erine Yii	nger er, City or Town, Sta	te, Zip Code)
Ma	alth an 27 la		Mrs. Sandra L. Fol		214	A East 6	th Street	t, Frede	rick, MD	21701
Baltimore,	Pages 1 and of He out: If item		20a. Method of Disposition Y Burial 2 Cremation 3 R. '4 Donation 5 Other (Specify)		Ob. Place of Dispo cemetery, crem Lesthaven M	natory or other pla	rdens Aug.	8, 2005	20c. Location - City Frederick	or Town, State , Maryland
Balti	permit. Departn Importe any inju		21. Signature of Funerel Service License)255 1	Keeney and Address	ind Bastor Church St	d PA Fu	neral Homerick, MD	e 21701
	3		23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the e cause on each fine.				•	•	Approximate fnterval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	zve	24516	_	Colo.	-) c	7467	Onset and Death
	/Medical Examiner			Due to (or as a co	nsequence of):					
	p t	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	nsequence of):					
	sate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
8760,	te be e ysiciar ne burii	calE								
9	death certifica e attending ph ed for use as th	/Med	IF FEMALE: 23b. Was decedent pregnant 2:	3c. If yes, outcome of pr					23d. Date of	delivery
O. Box		Physiclan/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1□Live birth 2□ 4□Pregnant at time 9□Unknown]Ectopic pregnand] Other (specify) _	cy		Month	Day Year
<u>α</u>	law requires that the de as been signed by the a 2 should be detached	y Phy	Part II. Other significant conditions con	tributing to death but no	nt resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	obacco use contribut	te to the cause of death?
ecords,	en sign	ed by						1 🗆 Y	res 21 0 3	Probably 4 Unknown
ecc	a so	Completed						24a. Was	an 24b. Were prior deat	e autopsy findings available to completion of cause of
a B	Th ate pag	e Cor	OF Man ages referred to modical				OC Place of Day	1□ Yes	21 No 1 1	Yes 2□ No
i Vital	Physician: this certific	To Be	25. Was case referred to medical examiner? 1 Yes 2	ospital:	2 ER/Outpatien	it 3□ DOA Ot	hor	ath <i>(Check only o</i> lome 5 43 Resid	dence 6 Other (Specify)
n of			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	Wo		28d. Describe h	now injury occurred	
Division	tan leat tor: the	Certification:	Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str		Yes 2 No	28f. Location (S City or Tow		r Rural Route Number,
Ö	To the Hospital or At within 24 hours after of To tha Funaral Diract completely filled in by	Cert								
	To the Hospital within 24 hours a To the Funeral Completely filled	edical		icien: To the best of my er: On the basis of exa and manner stated.						
	To the within 2 To tha comple	Me	29b. Signature and title of certifier		•	29c. Licen	se number		29d. Date signed (M	
}	M		8	Ed.	16		14625		August 4	, 2005
1	0		30. Name and address of person who co	mpleted cause of death + SE()8	(Item 23a) (Type,	Strept	Frede	erick	MM	21701
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature			/		
DH	Registr MH 17 Rev 1/20		AUG 1 0	2005	m A	Sperke				
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	*	1 - State Unpend Item 1. Decedent's Name (First, Middle, La			- OGI UIT	icaro	01 10	Jan		2. Date of Dea	th	005	3. Time of	Death
Physici /Medic		MARY LUVENIA	GASSAWAY							AUGUST		2005 ^{ear}		Ам
Examin	1.04	4a. Fecility Name (If not institution, giv SINAI HOSPITAL	e street and number)		41	b. City, Tov BAL	TIM	ORE C	ITY			ounty of Dea		
Funeral Director			Sex 7. Ag	e (In yrs. las 51	Yrs.	f Under 1 Y lonths D	Year Days	If Under 2 Hours	Min. 0	B. Date of Birth	95/3		rthplace (State or	
Maryland I-f ehow	tor	Usual Residence of Decedent 10a. State	/A		Town or Locati BALTIN								10d. Inside Cit	
with the	i Direc	10e. Street and Number 4034 PARK HEI	GHTS AVE	NUE		10f. Zip Co 2	121	. 5		1	-	on of What C		
hours after death with the Marylan urel', or iteme 23a or 28a-f ehow al Exacilier mast be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If If Yes, Give Year or Dates:	,		s Deceden es, specify Yes 20		panic Orig , Mexican Specify:	in? (Spec , Puerto R	ify Yes or No- ican, etc.)		. Race - Am Black, Wh pecify:	erican Indian, ita etc BLACK	
n 72 hours n"naturel", leuleal Ext	jeted	15. Decedent's E (Specify only highest gr	ade completed)		16a. Decedent (Give kind life. DO	t's Usual C d of work o NOT use r	Occupat done du retired)	tion uring most	of working	9	16b, Kind	of Busines	s/Industry	
illed within Hygiene. other then "	Somp	Elementary/Secondary (0-12)	College (1-4or	5+)	FLOF			ESIN			FLO	WER S	HOP	
nit. Pages I and 2 should be tiled within 72 ho arment of Haalih and Mental Hygiene. ortant: if item 27 ie marked other then "natu injury or other traumatic event, in a Modical a.	To Be (17. Father's Name (First Middle Last JIMMY WALKER) who, who, who was the same demand armon, who							(First, Middle, LICE C				
and 2 sho alth and 1 27 ie mu er trauma		19a. Informant's Name/Relationship (LORRAINE ANDE)		ISTER	19b. Mailing A) 3623	3 SP	RIN	GDAI	E A	VENUE	BAI	LTO.,	MD. 2:	121
permit. Pages 1 and Department of Haalth Important: if Item 27 eny injury or other troops.	694	20a. Method of Disposition 1		G Ack	ce of Disposition	on (Name on Footke	ÉSP	VET	C. Ci	ËM.8/1	200.100	OWI	n Town, State NGS MII	LLS
permit. Departm Importa eny inju		21. Signature of Fineral Service Lice 23a. Part1. Enter the disease, or comshock, or heart failure. List only	01									ME 21	215-63	93
Physician Medical Examiner Permit of the private	cai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Atherose Due to (or as b. Due to (or as c. Due to (or as	a conseque	nce of):									
The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal d	leath 3 □Ect	topic pregi					23	d. Date of de Month	,	/ear
ures that signed b id be deta	þ	Part II. Other significant conditions	contributing to death t	out not result	ing in the unde	erlying caus	se givei	n in Part I.				o contribute	to the cause of de	eath? Jnknow
- CG	Completed									24a. Was a autops perfor	sv	24b. Were a prior to death?		availabl ause of
Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ∑ Yes 2 □ No	Hospital: 1 ☐ Inpati	ent 2 X E	R/Outpatient	3□ DOA	Othe	r		(Check only or e 5 ☐ Resid		□Other (Sp	ecify)	
After After fune		27. Manner of Death 1 A Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		lnjury Work 1 🗆 Y		20	3d. Describe h			- ,,	
p ag in in	Certification:	3 Suicide 6 Could not to determined	286. Place of in	jury - At hom tc. (Specify)	ne, farm, street,	, factory, o	office		28	Bf. Location (S City or Tow		Number or F	Rural Route Numi	ber,
Hospital 4 hours a Funeral (fely fillad	Medical (hysician: To the best miner: On the basis of and manner st	of examination)
5 5 5 E	Σ	29b. Signature and title of certifier						number					nth, Day, Year)	
within 2-		· Panate Southe	4, MD			0	C 1	M E			AUGUS	ST 7,	2005	

Gardiner, Mary

9:15Am

Physic /Medi Examir

Funeral Director

	1 _ State	/laryland / [artment of He rtificate of D		nd Me		gien Reg. N	0000	25006
	Registrar 1. Decedent's Name (First, Middle, Last)			timouto of E		2	Date of De		8000	3. Time of Death
an	Amelai J. Gallo						Month	. D	2005	1:30p M
cal ier	4a. Facility Name (If not institution, give street and number	r)		4b. City, Town, or	Location of	Death		4	c. County of Dea	ith
	Berlin Nursing and Reha	bilitati	on	Berlin					Worches	ter
	1 DM 2 DE	Age (In yrs. last bit	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Month, Da	ıy, Yea	r) C	thplace (State or Foreign ountry)
	579 40 1896 This is a second of the second o	96	113.				July 1	13,	1909 Ne	w York
	10a. State 10b. County	10c. City, Tow	n or Lo	ocation						10d. Inside City Limits
to	Maryland Worchester	0	cea	n Pines						1 □ Yes 2√No
lrec	10e. Street and Number			10f. Zip Code				10g. C	itizen of What C	
al	24 Boatswain Drive		,	21811					United	
nue	11. Marital Status 12. Was Deceder Armed Forces	s?	13.	Was Decedent of His If Yes, specify Cubar	spanic Origi n, Mexican,	n? (Speci Puerto Ri	ify Yes or No can, etc.))-	14. Race - Am Black, Whi	
Completed by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 □ 3 ☑ Widowed 4 □ Divorced Year or Dates	.Λ.		1 ☐ Yes 2 ☐ No	Specify:				Specify: W	hite
ted	15. Decedent's Education		. Dece	dent's Usual Occupa	ition	A van deim a		16b.	Kind of Business	Industry
ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40	r 5+)		kind of work done d DO NOT use retired;	uring most (or working	,			
Соп	9th	G	ian	t Food				_	lerical	Retired
To Be	17. Father's Name (First, Middle, Last) Guiseppi (Unknown				18. Mother		<i>First, Middl</i> e ge1a	, маю	<i>on Sumame)</i> (Unk:	nown)
To	19a. Informant's Name/Relationship (Type, Print)	191	o. Maili	ng Address (Street a	and Number			er. City	or Town, State,	Zip Code)
	Evelyn Schaub (Daughter)		24	Boatswain	Drive	e, Oc	ean P	ines	s, MD 21	811
	20a. Method of Disposition	cemete		osition (Name of matory or other place	9)	Dat		20c.	Location - City or	Town, State
	1		t O	livet Cem		8, 2	.003	Was	shington	, DC
	21. Signature of Funeral Stephice Licenses	400153	>	2. Name and Addres		ьее				c. 6633 Old
	23a. Parti. Enter the disease, or complications that caus	ed the death. Do	not en	lexandria ter the mode of dying	Ferry g, such as c	Kd, ardiac or i	respiratory a	COD, irrest,	MD 207	Approximate Interval Between
	shock, or heart failure. List only one cause on each Immediate Cause (Final	we lent	. /	Cardiova	ser. la	~ [) CANE	pul.		Onset and Death
	disease or condition resulting in death) a. Due to (or a	as a consequence	of):	20101000	- Cargo		17000			(2009
L	Sequentially list conditions, b.		-0							
nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence	OI):							
dlcal Examiner	that initiated events c.	as a consequence	of):							
call	L d									
	IE EEALA E				-					
an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth	2 Fetal death	3 [☐Ectopic pregnancy					23d. Date of de Month	Day Year
Physician/Me	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	at time of death	5 [Other (specify)		_				,
, Ph	Part II. Other significant conditions contributing to death	but not resulting	in the u	inderlying cause give	n in Part I.		23e. Did	tobacco	use contribute t	to the cause of death?
d by	Renal Insut	ficien					10	Yes	2 □ No 3 □ P	robably 4 Unknown
Completed		(24a. Was		24b. Were a	utopsy findings available
omp							auto perfe	psy ormed? 2 23 4	death?	completion of cause of s
a	25. Was case referred to medical				26. Place	of Death (Check only			
To B	examiner? 1 Yes 2 No Hospital: 1 Inpa	atient 2 ER/O	utpatie	nt 3□ DOA Othe	or: 4 Nur	sing Home	e 5 🗆 Res	idence	6 □Other (Spi	ecify)
	27. Manner of Death 28a. Date of Ir 11 Natural 5 ☐ Pending (Month, I		Time o Injury	Work	(?		d. Describe	how in	jury occurred	
catl	2 Accident investigation	laine. At hama f			Yes 2 □ N		of Location	Stroot	and Number or E	Rural Route Number,
ertifi	determined 286. Place of	etc. (Specify)	arm, st	reet, factory, office		20	City or To	wп, Sta	ite)	nural modite mulliper,
Medical Certification:	29a. Certifier Certifying Physician: To the be									
fedic	(Check only one) 1 Medical Examiner: On the basis and manner	stated.		1 00 11				004.5		
2	29b. Signature and title of pertifier	. / ~ -	2	> Do	287	69		250. 6	3/3/0	35
2	30. Name and address of person who completed cause of	f death (Item 23a)	(Туре,	> Do	askl	High	way 1	Eu	vict-FSL	and Prayel
ate	31. Date filed (Month, Day, Year) 32. Fegi	strar's Signature	1	neals I						1770
rar	AUG 1 0 2005	HE SA.	105	-						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2005 thenno Cirac /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner ehobloter गाविशिया Mursino 2109onA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 31, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 1□ M 2፟ F 92 Yrs 1912 Maryland 214-34-4904 Dírector Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Marylend 10a. State 10b. County th end Mental Hygiene. 7 is markad other than "netural", or items 23a or 28a-f show traumatic evant, the Medical Examiner must be notified ≇t 1⊠ Yes 2 No Directo MD Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States of 610 Second Street 21403 death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Domestic College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Department of Health end Mental Hy, important: If item 27 is marked other any injury or other trained. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Blunt Elizabeth George Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 909 Monroe Street, Annapolis, MD 21403 Ms Velma Weems 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Aug 12 1 Burial 2 □ Cremation 3 □ Removal from State 2005 Annapolis, MD Annapolis Neck Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Miller's Metropolitan Chapel 21. Signature of Funeral Service Licenses 1922 Forest Drive Annapolis, MD 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Hemoschenotic Cardiovascular Diseas /Medical Examiner Due to (or as e consequence of) Physician/Medical Examiner led by the attending physician and deteched for use as the buriel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): 23b. Did tobecco use contribute to the ceuse of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pagt I. signed by to d be detech 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? cete hes been sig page 2 should b Completed nsiow. certificete hes IV dea stos lest aux 1 Tyes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Attending Physician: the funerel director, 26. Piece of Death (Check only one) Be Hospital: 1 Inpatient Other: 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 3□ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death M Injury 1 Natural 5 Pendina 1 Yes 2 No death. investigation 2 Accident i or Attend efter death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atter within 24 hours efter der To the Funeral Director completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) ecous bury 42036 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

2005

			Please T	Type or Print in Black In		-	-
			For	State of Maryland / Dep		Mental Hygie	ne
			State Registrar		ertificate of Death	Reg.	<u>~2005 25088</u>
	Physici	an	1. Decedent's Name (First, Middle, Last)			Month 7	Day Year NACO AM
	/Medic		Charles C. Gard		45 City Town and continue of Doct	100	4c. County of Death
	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death	City	1
			5. Social Security Number 6. Sec	x 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs.		n / a 9. Birthplace (State or Foreign
	Funeral Director			M 2□F 82 Yrs.	Months Days Hours Min.	Oct 18,1	922 Maryland
			Usual Residence of Decedent			000 1041	
	rylan	_	10a. State 10b. County	10c. City, Town or I	Location		10d. Inside City Limits XXYes 2 □ No
	Ba-f a	cto	Md. n/a	Balt	imore		
	hours after death with the Maryland turel', or Itema 23a or 28a-f show at Examiner must be notified at	Director	10e. Street and Number	- 336-963	10f. Zip Code	10g.	Citizen of What Country?
	a 23e			Street	21224	anaity Van or No	USA 14. Race - American Indian,
	er de Item	Funeral	11. Marital Status 1 ☑Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	o Rican, etc.)	Black, White, etc.
36	rs aft	by F	3 Widowed 4 Divorced	1 TyYes 2 □ No If Yes, Give Year or Dates: WW II	1 ☐ Yes 2 No Specify:		Specify: White
Ş	72 hours natural',	ed	15. Decedent's Edu	ication 16a. Dec	edent's Usual Occupation		b. Kind of Business/Industry
215	요 근위	ple	(Specify only highest grade Elementary/Secondary (0-12)	e completed) (Giv life.	re kind of work done during most of wor DO NDT use retired)	rking	
21	d withir giene. er then	Completed	12th		oan Officer		ommercial Credit
nd	be filed ntal Hygid od other svent, I	Be (17. Father's Name (First, Middle, Last)			me (First, Middle, Maid	den Sumame)
Maryland 21215-0036	should be and Mental marked c	70	Frank Grzeczk			Spath	,
lar	and and sm		19a. Informant's Name/Relationship (Ty		iling Address <i>(Street and N</i> um <i>ber or Ru</i> athsway Court l		
	s 1 and 2 if Health Item 27 I		Evonne Goetzel	/ Niece 3 K			Location - City or Town, State
Baltimore,	of L		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State cemetery, cr	ematory or other place)		
Ë	t. Pa rtmer rtant: rjury		*4 Donation 5 Other (Specify)				oltimore, Md.
Bal	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Licens				Funeral Home,PA
			23a Part 1 Enter the disease, or compol	lications that caused the death. Do not e			Approximate
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	Fil		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as consequence of):	rytallure		20.111
н	Examiner			Plei Lind F	=ffisions/	massi	(e)
	2	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	*	1.1000	
	d d ansit	Examine	Cause (Disease or injury that initiated events	Prelimo	nia		
60,	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as a consequence of):	•		
92	te be ysicia ne bu	cal		d			
687	death certificate b e attending physic of for use as the b	Physiclan/Medical	IF FEMALE:				#15 XX
Box	ith ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	B □Ectopic pregnancy		23d. Date of delivery Month Day Year
	t the des by the al tached fo	sicl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 5 9☐ Unknown	Other (specify)		
P.0	that the	Phy		ntributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobace	co use contribute to the cause of death?
ŝ	law requires that as been signed b 2 should be deta	by	Tatti. Other signmount conditions co.	Thibuting to could be not rooming in the	andonying daddo giron in r arri	1 ☐ Yes	
ecords,	w requ been should	Completed					()
Rec	o – o	npl				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
<u>=</u>	lan: The l					1□ Yes 2	
Vital	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:	Other	ath (Check only one)	0.570% - (0(1)
o		- To	1 Yes 2 No	28a. Dale of Injury 28b. Time	ant 30 DOA 40 Nursing P	28d. Describe how i	e 6 □Other (Specify) njury occurred
O	ding I h. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury			
Division	or Attending ter death. Irector: After Ir by the fune	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm,	street, factory, office		t and Number or Rural Route Number,
	2 g g c	Certification;	4 Homicide	building, etc. (Specify)		City or Town, S	iate)
	To the Hospital within 24 hours a To the Funeral completely filled			sician: To the best of my knowledge, de			
	he Hi in 24 he Fu pletel	Medical	(Check only 2 Medical Exami one)	iner: On the basis of examination and/or and manner stated.			
	To the within 2 To the complet	Σ	29b. Signature and Atle of certifier	· MD	29c. License number	29d.	Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDEFOUNCH MD.

31. Date filed (Month, Day, Year)

AUG 1 0 2005

2401 W Belvedere Ave.Balto.,Md2121

			For State Registrar		State of	Marylan		artmen			ind M		giene Reg. Nd.)	000	26000
	2		Decedent's Name	(First, Middle, La	st)							2. Date of De.	ath	005	9. Time'el Death
	Physici		Lil'	lie Luz	ealua I	Hov						August	Day	2005	9:55A M
	/Medic Examir		4a. Facility Name (If					4b. City,	Town, or	Location o				County of Dea	th
	CAMIIII	iei	Future	Care C	herrywo	od		Re	eist	erst	own		3	Baltin	ore
	Funeral		5. Social Security Nu	mber 6. S	iex 7	. Age (In yrs.	last birthday)		1 Year	If Under 2 Hours		8. Date of Bird (Month, Da	h		thplace (State or Foreign
48,	Director		218-28-2	373	□мХХГ	88	Yrs.	WIOTILITS	Days	Hours	141311.	Nov.1	19	16 Ma	ryland
	g ,		Usual Residence of [Decedent 10b. County		10a Cit	ty, Town or Lo	nonting							10d. Inside City Limits
	anyla shov	2		•											1 ☐ Yes XXNo
	Me M	Director	MD	Baltim	ore	R	eiste	rsto 10f. Zip					10a Citis	zen of What C	nuntry?
	with t	급	10e. Street and Num		n a			101. 21	211	126			-	U.S.A	
	36 23	Funeral	222 Cal	ndytuft	12. Was Deced	lent Ever in U	.s. ta.	Was Dece			nin? (Spe	cify Yes or No		14. Race - Ame	
	ter d	'n	1 Never Marrie	d X XMarried	Armed Ford	es?			1115		, Puerto	cify Yes or No Rican, etc.)		Black, Whi	
936	urs al	þ	3 ☐ Widowed 4		If Yes, Give Year or Dat			1 ☐ Yes 🕽	Ø X I No	Specify:				Specify: V	Wh i te
21215-0036	tiled within 72 hours after deeth with the Maryland Hyglene. ther then "natural", or Iteme 23a or 28e-f show ther then "hatlical Ezain" in a must be coallied at	Completed		15. Decedent's E			16a. Dece	dent's Usu	al Occupa	ation	t of worki	na	16b. Kir	nd of Business	/Industry
215	thin 7	ρie	Elementary/Secon		College (1-4	4or 5+)				during most ()					
	filed wi Hygien other th	5	8				Physi	cal	The			ssista			h Care
nd	d oth	Be	17. Father's Name (F									(First, Middle,			
yla	should be ind Mental I	2			Meekins				/0.			irgini			T- 0-4-1
Maryland	12 sh n and 7 is rr traurr	필	19a. Informant's Nar			1 1						Route Numbe			
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If itam 27 is marked other than "natural; or Iteme 23a or 28a-f show any Injury or other traumatic event. It is Medical Examples in unit be nulliked at Ance.		William 20a. Method of Dispo		y / Hus	20b. F	Place of Dispe	sition (Na	me of	- 1		ate		cation - City or	MD 21136 Town, State
Baltimore,	Pages nent of I int: If its iry or o	Ι.,	XXBurial 2	Cremation 3	Removal from Si	rate !	cemetery, cre				~ r 11	Q /19 /			wn, MD
뜵	it. P.	1	*4 ☐ Donation	/		го					_				hapel P.A.
Ba	permit. Departr Importa any Inji		1	fact.	Land	w									1s,MD21117
			23a. Part1. Enter the	e disease, or com	plications that car	used 🦙 deat								3	Approximate Interval Between
	Dhysician		shock, or heart Immediate Cause (F	italiure. Listionry Final	one cause on ea	ch line.		ķ.							nset ind Death
	Physician /Medical		disease or condition resulting in death)	-	a. Due to (o	r as consec	quence of):	<u></u>							(mining
	Examiner				_										
-		je l	Sequentially list con cause. Enter Under Cause (Disease or in	ditions, nediate	b. Qualto (a	r 35 a consec	wance of								
V	nd ransi	Examiner	that initiated events		c										
, 0,	be executed sicien and burial-transit	E	resulting in death) La	ast	Due to (o	ras a consec	quence of):								
68760		licat			_ d										
9 x	death certificat a attending phy d for use as the	Mec.	IF FEMALE:		23c. If yes, outc	ome of pregn	2001				3.72				
Вох	ath c	lan	23b. Was decedent in the past 12 r	ponths?	1 Live bir	th 2 ☐ Feta nt at time of c	aldeath 3	⊒Ectopic p ⊒ Other (s					2	23d. Date of de Month	Day Year
o.	uires that the dei signed by the a id be detached f	Physician/Med	1 ☐ Yes 2 € 9 ☐ Unknown	No	9□ Unknov		Jean St	_ Other (s	oochy)						
α.	that t ed by detar	h h	Part II. Other signific	cant conditions	contributing to dea	ath but not res	sulting in the i	ınderlying	cause giv	en in Part I.		23e. Did t	obacco u	se contribute t	o the cause of death?
ds	uires s sign ld be	d by		10hpu	knsin							10	Yes 28	3 □ P	robabiy 4 🗆 Unknown
Ö	w requir been si should	lete		Asia	· · · · · · · · · · · · · · · · ·							24a. Was	an	24b. Were a	utopsy findings available
Records,	he law e has l	Completed	-	7010	a trai								rmed?	prior to death? 1 ☐ Yes	completion of cause of
Vital	ician: Th certificate ector, pag		25. Was case referre	ed to medical	enva					26. Place	of Death	1 Yes		I I TES	2 2 140
>	Physician: this certifica ral director, p	To Be	examiner?		Hospital: 1 🗆 In	patient 2] ER/Outpatie	nt 3 D	OA Oth	- 77	/	me 5 ☐ Resi		S □Other (Spe	ecify)
ō	g Phys er this eral di	n: T	27. Manner of Death	_	28a. Date of (Month		28b. Time o		28c. Injun Wor			28d. Describe			
Ö	Attending Production of the Atterment of the funer by the funer	atio	1 ☑Natural 2 ☐ Accident	5 Pending investigation	in	, Day roar)	injury	М		Yes 2 □	No				
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	200. Place	of Injury - At h	nome, farm, st	reet, factor	y, office			281. Location (ural Route Number,
Ō	tal or rs afte al Dir	Cer													
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	icai	(Check only		hysician: To the t miner: On the ba	sis of examina									
	the hin 24	Medical	one)	alle et es Ass	and manne	er stated.		20	c. Licens	e number			29d Dat	e signed (Mon	th Day Year)
	To Too		29b. Signature and	In or certifier	/ min			28			566			•	3
				170	(11)	-4	- 00 . 7	Deiter		V / 5			8	1010	ט
	10		30. Name and addre	ess of person who	completed cause	or death (Ite	(1ype	38	G	Tee.	~e	Tre	e /	El	21208
32		ate	31. Date filed (Monta	h, Day, Year)	32. Re	strar's Sign.	ature	4		,-00	_				7
	Regist			AUG 1 n	2005	Colors .	K.	back	1						

			For State Registrar	State of M	aryland /		artment of H tificate of L			giene Reg. No. 2	2005	26090
	Physici		1. Decedent's Name (First, Middle, Las Frances Lee						2. Date of De Month Aug 1,	ath Dav		3. Time of Death 3:34. P M
	/Medic Examin		4a. Facility Name (If not institution, given				4b. City, Town, or Clinton			4c. C	County of Death	eorge's
	Funeral Director		5. Social Security Number 6. S 1 247 54 5473		ge (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		3, 19	9. Birthp 933 Sot	place (State or Foreign ntry) ith Carolina
	72 hours after death with the Maryland naturar, or items 23e or 28e-f show iteal Examinar must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince (10e. Street and Number	George's	10c. City. To		cation			10a. Citize	en of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ tho
	23a or	ai Dir		rratts Roa	ıd			0735			ited Sta	
396	urs after dea at', or items	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	?		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 [X] Mo	ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		4. Race - Ameri Black, White, Specify: Wh:	
21215-0036	c °_ ∰	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or		(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired ad of Ope	during most of w			d of Business/In	
Maryland 2		To Be Co	12 17. Father's Name (First, Middle, Last Luther Ja		<i>I</i>			18. Mother's N	ty Lee Hi		Gumame)	
Jary	s 1 and 2 should be f f Health and Mental I item 27 is marked or other traumatic eve		19a. Informant's Name/Relationship (19		ng Address <i>(Street a</i>	and Number or	Rural Route Numb	er, City or	Town, State, Zij	o Code)
Baltimore, 1	Pages 1 and 2 ent of Health nt: if Item 27 ry or other tra		Vanessa Howle (20a. Method of Disposition Valuatial 2 Cremation 3 C 4 Donation 5 Other (Specia		20b. Place ceme Resu	of Dispo	I Suffact sition (Name of matory or other plac tion Cem	e) Aug 8		20c. Loca	ation - City or T ton, Ma	
Baltii	permit. Pages: Department of H Important: if ite any injury or ot		21. Signature of Funeral Service Lice	hsee mod	0257	A	Name and Address lexandria	Ferry	Rd, Clint	ton, l	me,Inc MD 207	
8760,	Physician / Medical Examiner physician and physician and physician ite printing the	lical Examiner	23a. Part 1. Enter the disease, or comshock, or heart lailure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a:	ine. Yyy 0 () s a densequence s a consequence s a consequence	ee of):	0 1	<i>g</i> , e				Interval Between Onset and Death
P.O. Box 68	ne death certific the attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 ☐ Fetal dea at time of death		Ectopic pregnancy Other (specify)			23	3d. Date of deliv Month	very Day Year
	equires that the services that the en signed by ould be detact	by	Part II. Other significant conditions	contributing to death	but not resulting	g in the u	nderlying cause giv	en in Part I.	23e. Did 1			the cause of death?
Il Records,	The ate h page	Completed	ambe Renal	Euline					24a. Was auto perfo 1 Yes		prior to co death?	opsy findings available ompletion of cause of
of Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2□ER/	Outpatier	nt 3□ DOA Oth	00	Death (Check only only only only only only only only		□Other (Speci	ifv)
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Division	tal or Atters as after de al Directo	Certification:	3 Suicide 6 Could not to determined	28e. Place of I	njury - At home, etc. (Specify)	larm, st	reet, factory, office		28f. Location (City or To	Street and wn, State)	l Number or Rui	ral Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exa	hysician: To the bes miner: On the basis and manner s	of examination	dge, deat and/or in	vestigation, in my o	pinion, death o	ace, and due to the ccurred at the time,	date and p	place, and due	to the cause(s)
	or with	>	29b Signature and title of certifier	Wish	MD		29c. Licens	5 5120		Aug	signed (Month	nd 2005
1	2/1		30. Name and address of person who Richard Palmer	completed cause of	death (Item 23)	a) (Type,	Print) e SE Smt	310 W.	is hing hin D	2 2	20032	
	St Regist	ate rar	31. Date filed (Month, Day, Year) -	1 0 20.0\$	trar Signature	B	SE Smt	,				

		1 - For Stete Registrer	State of Marylan	d / Depa		Health and	Mental Hyg	giene Reg. No. 2015	26001
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last Frances 4a. Facility Name (If not institution, give	Ann street and number) www.Dr/ve		Chet	or Location of Deal	4re	4c. County of Death	George's
Funeral Director		5. Social Security Number 402-60-2334 Usual Residence of Decedent	x 7. Age (In yrs.) ☐ M 2以 F 62	ast birthday) Yrs.	If Under 1 Yea Months Day			9. Birth (y, Year) Co. 1, 1943 KY	nplace (State or Foreign untry)
death with the Maryland ms 23a or 28a-f show Fristst be trafficat at	Director	10a. State 10b. County Maryland Prince Ge		Chelt	enham				10d. Inside City Limits 1 Yes 2 No
th with the 23a or 2 ust be re	al Dire	10e. Street and Number 10402 Angora Driv	e			0623		10g. Citizen of What Co U.S.A	
je 2 2	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of If Yes, specify Cu	Hispanic Origin? (ban, Mexican, Puel o <i>Specify:</i>	Specify Yes or No- rto Rican, etc.)		
d within 72 hours after giene. Ir then "naturel", or Ite	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	cation de completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use retii	e during most of wo red)	prking	Financial Credit Un	-
be file ntal Hy of othe	To Be Co	17. Father's Name <i>(First, Middl</i> e, <i>Last)</i> Jasper	Thomas	<u> </u>		18. Mother's Na Mary	Ethel D		
nd 2 shoulth and 27 is mu	ľ	19a. Informant's Name/Relationship (7 Lisa Tippett (Da						er, City or Town, State, 2 ton Park , MD	
೨ ೫೭= ೬		20a. Method of Disposition 1 Burial 2 A Cremation 3 4 Donation 5 Other (Specify	Lee	e Crem	-	negu	Date st 9.	20c. Location - City or Clinton, M.	aryland
permit. Pa Departmen Importent: eny injury		21. Signature of Fureral Service Incent	M00153					al Home, In Koad Clint	
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the death one cause on each line. a	z C	ter the mode of d		ac or respiratory ar	rrest.	Approximate Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classes or injury that initiated events	b. Due to (or as a conseq	uence of):				=	
auth certificate be executed attending physician and for use as the burial-transit	cal	resulting in death) Last	Due to (or as a conseq	uence of):			. —		
· o o o	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Q No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	□Ectopic pregnar □ Other (specify)			23d. Date of del Month	ivery Day Year
w requires that the been signed by the should be detach	by	Part II. Other significant conditions or	ontributing to death but not res	ulting in the u	underlying cause	given in Part I.		obacco use contribute to Yes 2□No 3□Pr	/
The lar ate has	Completed						24a. Was autop perio 1 🗆 Yes	an 24b. Were au prior to death? 2 No 1 Yes	topsy findings available completion of cause of
ding Phyeicien: The J. After this certificate funeral director, pag	tlon; To Be	27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 Inpatient 2 Month, Day Year)	ER/Outpatie 28b. Time of Injury	of 28c. In	Other: 4 Nursing	_	one) dence 6 □Other (Specific or Specific or Specifi	cify)
LIVISION tel or Attending s after death. el Director: After ed in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, si			28f. Location (S City or Tox	Street and Number or Ru wn, State)	ıral Route Number,
To the Hospitel or within 24 hours afte To the Funerel Dir	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, dea ution and/or in	th occurred at the nvestigation, in m	time, date and plac y opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	Alisto I	00	29c. Lice	ense number	27	29d. Date signed (Mont.) August 8	h, Day, Year)
P5.	1	30. Name and address of person who	completed cause of death (Iter	n 23a) (Type	Print)	Drine	Cherry	L Man	land
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Regionar's Signa	ature	Ancile		-	11 0	

			State of Maryland 1- State Amend Item 19a per fh G846 8	/ Depa - 10 e/	intment of H	ealth and N Death		ene 2005	26092
	Physicia	an	Decedent's Name (First, Middle, Last)		HOWARD		2. Date of Death	, Day 2005 Year	3. Time of Death 1:00 P M
	/Medic	al	THOMAS F. 4a. Facility Name (If not institution, give street and number)	<u>_</u>	4b. City, Town, or	Location of Death	1	4c. County of Dea	
	Examin	er	130 SLADE AVENUE #221		,, ,	BALTIMO	RE		TIMORE
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) SEPT. 18,	(1927 9. Bi	rthplace (State or Foreign country) MD
and	3		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Lo	cation				10d. Inside City Limits
Maryl	fied at	tor	MD BALTIMORE			BALTIMO	RE		1 ☐ Yes 2 🕅 No
th the	or 28a e nati	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What C	
ath wi	3 23a		130 SLADE AVENUE #221	40.1		21208	- of Vacasha	14. Race - Am	USA
Illed within 72 hours after death with the Maryland	rai", or itams 23a or 28a-f ehov Examiner rusi be notified at	by Funerai	11. Marital Status 1 Never Married 2 M Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 No NAVY If Yes, Give	- 1	Vas Decedent of Hi f Yes, specify Cubar I □ Yes 2 🕱 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
72 hou	"netural". dical Exp		15. Decedent's Education (Specify only highest grade completed)	6a. Deced	lent's Usual Occupa	ition uring most of work	kina 16	6b. Kind of Busines	s/Industry
d within 7	f Health and Mental Hygiene. Item 27 Is marked other than "netun other treumatic event, the Mcdral	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	MACH	DO NOT use retired,			&O RAILRO	DAD
P Q	and Mental Hygiene. Is marked other than eumatic event, the Me	To Be (17. Father's Name (First, Middle, Last) GEORGE	HOWA	RD	18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	PERLMAN
2 should	ls mai		Con		•			City or Town, State,	
, and	Health em 27 ther to		KANDI HONAKO / SI K	. (D'	-11 /11			oc. Location - City o	
Pages	nt: If is				on (Name of Patory of other place OM MEMORI		9/2005	REISTERS	STOWN, MD
permit.	Department of Health a Importent: If Item 27 Is eny injury or other treuong.		21. Signature of Puneral Service Licensee					N & BROS. KESVILLE	, INC. , MD 21208
			23a. Part1. Enter the disease or complications that caused the death. I shock, or heaf failure List only one cause on each line.						Approximate Interval Between Onset and Death
	nysician Medical		Immediate Cause (Final disease or condition resulting in death)		oma	046	ung		Oriset and Death
	xaminer		Due to (or as a consequent Sequentially list conditions.				U		
ted	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):					
, exec	sician and burial-transit		that initiated events c. Due to (or as a consequent or as a consequen	ce of):					
cate be	physici the bu	dicai	d						
The law requires that the death certificate be executed	the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deati 9 □ Unknown	ath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
ires that	been signed by the should be detached	by	Part II. Dther significant conditions contributing to death but not resulting	ig in the ur	nderlying cause give	n in Part I.			to the cause of death?
The law reo	ite has been bage 2 shou	Completed	Dichette Nangal	1			24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of
clen:	ertifice ector, p	ВеС	25. Was case referred to medical examiner?		-		th (Check only one)		
Physic	this c	To:	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER	Outpatien b. Time of		4 Nursing H	ome 5 PResiden 28d. Describe how		ecify)
ding	th. : After s funer	tion	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Work	?` ′es 2 □No		,,	
lor Atte	after dea Director	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
the Hospitel or Attending Physicien:	within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tim restigation, in my op	e, date and place, inion, death occur	and due to the cau red at the time, date	se(s) and manner a e and place, and du	is stated. e to the cause(s)
Toth	within To the compl	Me	29b. Signature and title of certifier	Im	29c. License	number 5	3 290	d. Date signed (Mon	th, Day, Year)
11	1		30. Name and address of person who completed cause of death (Item 23	(Type,	Piny Ker	ille t	tagle	03113	3
	Sta		31. Date filed (Month, Daly, Year) 32. Registrar's Signature	20	boarde		3		
	Registr	वा	AUG 1 0 2005 Reserved	15.	Par de la constante de la cons				

State of Maryland / Department of Health and Mental Hygiene Fermin Jiminez Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 AŬĞÜST **Physician** 6:20A. FERMIN JIMENEZ-JIMENEZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY BALTIMORE HARBOR HOSPITAL CENTER 8. Date of Birth (Month, Day, Year, JULY 6, 19 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 33 Yrs 1972 MEXICÓ 332-86-3101 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State rai', or items 23s or 28e-f shor Examiner must be notified at NORTH 1 ☐ Yes 2 X No CONCORD CAROLINA CONCORD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number MEXICO 28027 509 LITTLE CREEK LANE, N.W. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc filed within 72 hours after 1 Never Married 2 Married 1 X Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: HISPANIC If Yes, Giro Year or Dates: MEXICAN þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 7 is marked other than "nature treumatic avant, the Medical Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER BUILDING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fite Department of Health and Mental Hy important: if Item 27 is marked oth any jury or other treumatic avant 2008. CONSUELO JIMENEZ VICENTE JIMENEZ ALVARADO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 509 LITTLE CREEK LANE, N.W., CONCORD, NC 28027 MARIE DE JESUS ALVARADO Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Crem 20b. Place of Disposition (Name of EL AGUACATE ARROYOCECO QUERETARO 2 Cramation 3 Removal from State QUERETARO, MEXICO 4 □ ponation 5 □ Other (Specify) 21. Sign threath a eral Service 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Mul **Physician** Due to (or as a consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off Examine or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit resulting in death) Last Due to (or as a consequence of). P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Month in the past 12 months? 5 Other (specify) 4 Pregnant at time of death ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. page 2 should be 28 No 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 X Yes 2 □ No this 28d. Describe how injury occurred on struck 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. 5:33A investigation 8-6-05 po vehicle 2 Accident 3 Suicide the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) EB 895 47 filled in by 4 Homicide Potee St. Baltimore, MI High wav within 24 hours a To the Funerel D Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and AUGUST 6, 2005 O.C.M.E. 30. Name and address of person who comp cause of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE MARYLAND 21201 32. Segistrar's Signature 31. Date filed (Month, Day, Year) AUG 1 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. (ime of Death 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 1:25P **Physician** Jones 2005 August Ronald Jon

4a. Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Randalstown

| Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | Game | G Baltimore Northwest Center Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F 214-88-8548 May Yrs. maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County an "natural", or Items 23a or 28a-f show Wedical Examinat must be notified at 1 Yes 2 No Woodlawn Baltimore **Funeral Directo** mo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "rectany or other traumation". Circle Apt. 103 Sandown 21244 USA Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□Yes 20 No Specify: Black Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Trucking ruck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Leroy Jones Jones Lydia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7112 Sandown Circle Apt. 103 Woodlawn, mb 21244 Lydia Jones Herrington 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest V.A. 8-12-05 4 ☐ Donation 5 ☐ Other (Specify) Quings mills, MD Gary P. March Funeral Home P.A. 270 Fredhilton Pass Balto mb 21229 21. Signature of Funeral Service License 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastrointestinal
Due to (or as a consequence of): hemorrhage **Physician** >8 hours disease or condition resulting in death) /Medical **Examiner** orta Imonth hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed liver hronic resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Hepatitis disease >5 months Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 2 No 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Acute 2 🗆 No rena 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Systemic intlammatory 24a. Was an syndrome response autopsy performed? Yes 2 No mellitu Type II dia bates
25 Was case referred to medical
examiner? Alcoholism 1 ☐ Yes 26. Place of Death (Check only one) 1 ☐ Yes 2 ▼ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 2 □ No 1 Yes 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier D28462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Center Randallstown Northwest Boston 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 0 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 32 Tilme of Dobath Month 8 **Physician** Carlos Jacobs, Sr. James 12:30pM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore NA 4202 Standwood Avenue If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex 1 2 M 2 ☐ F **Funeral** Days Hours Months Md. 69 216-30-2405 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 ie marked other then "neture!" ~ " any injury or other treumatic even." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 No Md. Baltimore NA Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 4202 Standwood 21206 Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes X ☐ No Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Lord Baltimore Press 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sullivan John Sarah Jacobs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris Mosley 226 Branch Street, Berlin, Ex-Wife Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Voshell Mem. Garden 8-13-05 Dundalk, Md. ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. l ande March F.H. East 1101 E. North Ave. 么 ware 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed?

1 Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes ☑ No P 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fo to, within 24 hou, the Funerel D' 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 5201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

				State of Maryland / Department of Health and N 1 - State Registrer Certificate of Death	Mental Hy	giene	F 26006
		Physici	an	Decedent's Name (First, Middle, Last)	2. Date of De Month	Day Ye	
		/Medic	al	Harry Stone Lawson	August	04 2005 4c. County of D	
		Examin	er	Harford Memorial Hospital Havre de Grace		Harford	
		Funeral Director		5. Social Security Number 6. Sex 12 P 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bi (Month, Di 03/11/1	rth ay, Year) 9.	Birthplace (State or Foreign Country) VLYLAND
				Usual Residence of Decedent	Ψ3/11/1	727 MC	10d. Inside City Limits
		ith the Marylan or 28a-f show	ō	10a. State 10b. County 10c. City, Town or Location MD Harford Aberdeen			1 XYes 2 No
		or 28a-	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
		s 23a c				USA 14 Barn A	merican Indian,
	(0	s I and 2 should be filed within 72 hours after death with the Maryland Fleatht and Mental Hygiene. I health and Mental Hygiene. Items 23a or 28a-f show titem 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Exercities Invat be italified.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 13. Was Decedent of Hispanic Origin? (Sp. 14 New Process) 14. Was Decedent of Hispanic Origin? (Sp. 15 New Process)	o Rican, etc.)		hite, etc.
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0	215-	in 72 h n "natu fadica	Completed	15. Decedent's Education (Give kind of work done during most of work of the completed) (Give kind of work done during most of work done) (Give kind of work done) (Give kin	rking	16b. Kind of Busine	ess/Industry
6:05/	212	ad with giene.	Com	Elementary/Secondary (0-12) College (1-4or 5+) 12th Firefighter		U.S. Gov	ernment
و	and	t be file ntal Hy ed oth	Be	u 17. Father's Name (First, Middle, Last) 18. Mother's Nam		e, Maiden Sumame)	
	Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, ITE M.	Ţ	Harry Arthur Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru.	Marion : Iral Route Numb		e, Zip Code)
5	-	1 and 2 s Health an em 27 is ither trau		Delores Torrence- Companion 1933 Bennett Rd., Aberd	deen, Mi		
ð	Baltimore	g = 5 0 = 5		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place)		20c. Location - City	
1	altin	permit. Pa Departmen Importent: any injury once.				Aberdeen,	
3	ä	permi Depar Impo any ir once	_ 4	21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Mutchell-Smith Fune 123 S. Washington. 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Havre o	le Grace, I	MD 21078 Approximate
	0,	Medical Examiner / Medical Exami	Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enser Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	ty	y Failur	Interval Between Goset and Death One Week One Week
534	x 68760	leath certificate be attending physicis I for use as the bu	hysician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	Messe	22d Date of	delivery
212.22.65	.O. Box	ath titer or u	hysician	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of Month	Day Year
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WSON	Vital	Physicien: this certific ral director,	o Be	examiner?		one) idence 6 ☐Other (5	Speciful
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Harr		Hospitel or Attended Hours after deatles Funerel Director: etely filled in by the	edical Ce				
		To the To the comple	Me	29b. Signature and title of certifier 29c. License number 29c. License number	4	29d. Date signed (M	onth, Day, Year)
•	,	(X)		30. Name and address of person who completed cause of death (MORIZI	HOSPIT	T LOUS
		1		DAVID C. BRICK, M.D. S. UNION AVENUE			
		Sta		e 31. Date filed (Month, Day, Year) 31. Registrar's Signature	7		3

DHMH 17 Rev 1/2001

			1 - For State Registrer	State of Ma	aryland / I		rtment tificate			d Mental F	-	2005	26097
	Physic /Medi			Rley						2. Date of Month	Death OH	200°S	3. Time of Death 1152 PM
	Exami	ner	4a. Facility Name (If not institution, give University of Mary 16 5. Social Security Number 6. Se	and medica	Center			Bull	Location of D			County of De	
	Funeral Director			M 21√2 F	23	Yrs.		Days		Hrs. 8. Date of (Month, May 5	Day, Year	32 Ma	nthplace (State or Foreign Sountry) TYLANd
	the Marylan 28a-f show notified at	ctor	10a. State 10b. County Maryland Baltimo	re	10c. City, Tow		^{ation} Balti	more	2_				10d. Inside City Limits 1 ☐ Yes 2 No
	ath with the 23a or 23 ust be no	ral Dire	10e. Street and Number 4405 Camellia R	oad			10f. Zip C	ode	21236			tizen of What C	country?
9800	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If itam 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic avant, the Medical Examinat must be notified at	d by Funeral Director	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:	Ever in U.S.		as Decede Yes, specif		spanic Origin n, Mexican, P Specify:	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Am Black, Wh Specify:	
21215-0036	id within 72 h giene. er than "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		+)	(Give k		done du retired)	tion uring most of SSISTA		16b. k	Cind of Busines.	
Maryland	should be filed with nd Mental Hygiene, i marked other that umatic avant, ITE N	To Be	17. Father's Name (First, Middle, Last) John Joseph Ma						Nanc		abson		
_	1 and 2 sho Health and am 27 Is ma ithar trauma		19a. Informant's Name/Relationship (T. Mr. John Marley	үрө, Print) (father) 4	4405	Came	llic		Rural Route Num Baltime	ore,	MD 212	36
Baltimore	Pa ant ant		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,)	20b. Place of cernetes St. Ma	iry, crema icha	atory or oth el Lu	er place th .	ch. 8	Date 8/8/2005	Bal	ocation - City o timore,	Maryland
Bal	permit. Pag Department Important: I any injury o		21. Signatur Juneral Service Licens			97	05 Be	lair	ı Rd.,	Schimunek Baltimo	ze, M	eral Ho D 2123	
	Pnysician		23a. Part1. Enter the disease, or comp shock, or reart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each in	the death. Doi		the mode			diac or respiratory	arrest,		Approximate Interval Between Onset and Death CULAS
	/Medical Examiner	_		Intra	e consequence	l I	Ische	m	a				days
8760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Hyper	COUCUI a consequence	labi	e s	ak					years
P.O. Box 68	it the death certific by the attending p tached for use as:	Physician/Medle	in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1	2 Fetal death time of death	5 🗆 (ictopic preg Other (spec	ify)				23d. Date of de Month	livery Day Year
	w requires that been signed should be det	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting in	n the und	erlying cau	se given	in Part I.		tobacco i		o the cause of death?
al Records,		Completed								24a. We aut per 1 🗆 Yes	opsy formed?	24b. Were a prior to death?	utopsy findings available completion of cause of
ion of Vital	Attending Physician: r death. actor: After this certific by the funeral director,	atlon: To Be	27. Manner of Death Natural 5 Pending 2 Accident investigation	lospital: Inpatier 28a. Date of Injun (Month, Day	28b. T	tpatient Fime of njury	3 DOA 28c	Other: Injury a Work?	4 🗌 Nursin	Death (Check only g Home 5 Re 28d. Describe	sidence		icify)
Division	in Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, far . (Specify)	rm, stree	t, factory, o	ffice		28f. Location City or T	(Street an own, State	d Number or R.)	ural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	edical	29a. Certifier (Check only one) Certifying Physical Exemi	sicien: To the best o ner: On the basis of and manner stat	f my knowledge examination and ed.	d/or inves	ccurred at t stigation, in	the time my opir	, date and pla nion, death or	ace, and due to the	e cause(s) e, date and	and manner as place, and due	s stated. to the cause(s)
}	Tot with Com	Y	29b. Signature and title of certifier				29c. L	65	38		29d. Dat	e signed (Mont	h, Day, Year) DDS
4			30. Name and address of person who co	empleted cause of de	ath (Item 23a) (Type, Pri	ma Ma	yl	and	Meduly	O Cer	ukn	
	Sta Registr	te ar	31. Date filed (Month, Day, Year) AUG 1 0 20	05 32 Aegistra	's Signature	Apa	die	0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DOROTHY Ν. **MYERS** alle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore St. Elizabeth's Nursing Home If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 □ F 214-20-1429 94 Director May 16, 1911 Maryland Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Modical Exeminar must be notified at 1 ¥ Yes 2 ☐ No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1229 William Street 21230-4318 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Loom Operator Linen & Thread Co. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ital John J. Bensley Georgianna W. Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Rickards Lane, of Health If item 27 Adella M. Hlafka (Daughter) Camden, Delaware 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 □ Cremation 3 □ Removal from State Department o important: If any injury or once. Cedar Hill Cemetery |8/12/05 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.

23a. Part. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Baltimore, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Tova Juels **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate has autopsy page 2 performed? 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Certification: Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 😂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier under (Item 23a) (Type, Print)
under choice love bald un 21228 completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 0 2005 I Walnut Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** William C. Mackert 4 4 AUGUST 2005 6:45 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore 8. Date of Birth (Month, Day, NOV. 4, Birthplace (State or Foreign 6. Sex 1 M 2 □ F Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Märyland Yrs 78 214-22-9962 Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "naturel", or Items 23a or 28e-f show 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County rei', or items 23a or 28e-f show Examiner outst be notified at 1 Yes 2 □ No Director Baltimore. Maryland N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 3425 Woodstock Avenue Α. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Buyer Grocery Store 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Winfield R. Mackert Ruth W. Weber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar importent; If item 27 Is any injury or other treu once. (P.O.A.) 6305 Belair Road, Baltimore, Maryland 21206 Samuel A. Culotta 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/08/ 2005 Baltimore, Maryland Baltimore Cemetery ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) PNEUMONIA-LEFT LOWER LOBE HOURS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence oil. Examine The taw requires that the death certificate be executed burial-translt Due to (or as a consequence of): ettending physician Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? as been signed I 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 / 0 1 Yes 3 Probably 4 Unknown ALZHEIMER'S DEMENTIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 Yes Hospitei or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 Mo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EN/Outpatient 3 DOA ပ္ this te of Injury (Month, Day Year) 28c. Injury at Work? 27. Mapner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 26b. Signature and title of certifie D25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. 76/21 OSLER DRIVE TOWSON, MARYLAND 212/24 CERALLOS (onth, Day, Year) AUG 1 0 2005 State Registrar

			State of Maryland / Department of Health and Certificate of Death	Mental Hy	giene	
	Physic		1. Decedent's Name (First, Middle, Last) JUDITH BERKLEY OWEN MATTHEWS	2. Date of De Month August	Day	2 Time of Dealin 0
	/Medi Examii		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De		4c. County of	of Death
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	rs. 8. Date of Bir		1timore 9. Birthplace (State or Foreign (Quintry)
	Director		215-32-3773 1□M XXF 90 Yrs. Months Days Hours Mi	Septembe	r 12,1914	Virginia
	the Maryland 28e-f show	7	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
1	the Marylar r 28e-f show	Directo	Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code		10g. Citizen of W	1 Tyes No hat Country?
ω	ath with	ralD	612 West Joppa Road 21204		US	
7	within 72 hours after death within 72 hours after death within "natural", or items 234 has Medical Examiner must	by Funeral	11. Marital Status 1 □ Never Married 12 □ Married 13. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put Yes, Give Year or Dates:	(Specify Yes or No erto Rican, etc.)	5- 14. Race Black Specify:	- American Indian, c, White, etc. White
fer m	in 72 hours "natural",	oletec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wife. Do NOT use retired)	vorking	16b. Kind of Bus	siness/Industry
	be filed with that Hygiene.	Completed	5+ Teacher			imore City
9	laryiano Z I	To Be			, <i>Maiden Sumame</i> bee Berk	
5			19a. Informant's Name/Relationship (Type, Print) Judith Matthews Jelenko DTR 612 West Joppa Road 7			
,	- m		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		Z IZU4 Dity or Town, State
oko	Dallillo permit. Page Department o Importent: If eny injury or once.		ADDonation 5 Other (Specify) GreenMount Cemetery 8/8	3/05		re, Maryland
V	Dentit. Departingont		21 Jignature of Funeral Javide Licensee 22. Name and Address of Facility M	litchell- ad Balti	Wiedefeld more, Mai	J Funeral Home ryland 21212
		ľ	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):			4 days
	Examiner	ē	Sequentially list conditions, if any, leading to immediate Due to (gr as a consequence of): Due to (gr as a consequence of):			(yr
V	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Mulmurs Due to (or as a consequence of):			10 yes
77	cate be executed cate be executed physician and the burial-transit	dical E	d			9
0 0	A 00 sertificat ding phy se as th	/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			
101	• = you	Physiclan/Me	23b. Was decedent pregnant to the past 12 months? 1		23d. Date Mont	of delivery th Day Year
Jan	w requires that been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			bute to the cause of death? 3 Probably 4 Ponknown
7	- a a	Completed		24a. Was autor perfo 1 Yes	osy ormed? de	ere autopsy findings available for to completion of cause of eath?
3a	ysicien: ysicien: is certific director,	To Be	examiner?	eath Check onl	one dence 6 □Other	(Specific)
	ding Phy		27. Manner of Peath 1. ☐Natural 5 ☐ Pending (Month, Day Year) 1. ☐Natur		how injury occurre	
, o aciein	att att	Certification:	2 Accident 3 Suicide 4 Homicide Ould not be determined See. Place of Injury - At home, farm, street, factory, office	28f. Location (: City or Tox	Street and Number vn, State)	r or Rural Route Number,
	To the Hospitel or Attu- within 24 hours after de To the Funerel Directo completely filled in by the	edical C	29a. Certifier (Check only one) 1	se, and due to the curred at the time,	causs(s) and man date and place, ar	nar as stated, nd due to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)
			D18822		8/7/	105
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD HADERSAM (ITEM 23a) (Type, Print)	RD, to	rkton,	MD 21120
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 0 2005	/		-

			1 - Stata Amend Item 1	State of Maryl per phy G84	and / Dep 6 8-10-6	artment of F 05 tas Prificate of	lealth and Me <i>Death</i>	ntal Hygien Reg. N	2005	26101
	Physici	an	1. Decedent's Name (First, Middle, Las					Date of Death		3. Time of Death
	/Medic	al	1077	G.		THE POS	y Leasting of Dooth	AUGUST 9	200 c. County of Dea	
	Examin	ier	4a. Facility Name (If not institution, give Chapel Hill Nursi				ellstown		Baltimo:	
	Funeral Director		Social Security Number 6. S.		rs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day Year July 22, I	9. Bir 912 Ma	thplace (State or Foreign ountry) aryland
	ס		Usuel Residence of Decedent							
	show	٦	10a. State 10b. County		City, Town or L					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-f	rect	Maryland N/A	1	Baltim	10f, Zip Code		10g, C	itizen of What Co	
	h with	a Di	1516 Belt Street			212	.30		U.S.A.	-
36	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "neturel", or flems 23e or 28e-f show event, it is Medical Exert in trivial for indifficial at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 ☑ No	lispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify:	
9-0	72 hou natura icul E	ted	15. Decedent's Ed	lucation	16a. Dece	edent's Usual Occup	pation	16b. H	Cind of Business	
21215-0036	within 7 ene. than "n	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of working d)		_	
72	filed w Hygler kther th		10 17. Father's Name (First, Middle, Last)	N/A	R	etail Sal	.es 18. Mother's Name (i			Dept. Store
auc		To Be	Alonza		Matthew	'S	Ann	Jennet		Stiner
Maryland	2 sh and Is II	-	19a. Informant's Name/Relationship (7) Jennette Hamilton	**			and Number or Rural F Drive Hano			
	1 an Heal em 2 ther		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Pomovol from State	b. Place of Disp cemetery, cre	osition (Name of ematory or other place	ce) Dat	e 20c. L	ocation - City or	
Baltimore,	Pag nent ant: I		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	,) L			ery 8/13/0			Maryland
Ba	permit. Departr Importa any inja		John F	belling	M 1	cCully-Po 30 East F	Syniak Fun Ort Ave. B	eral Home altimore,	, P.A. Marylar	
	Physician /Medical		23a. Part1 Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the done cause on each line.	14- D4-	And the second second section of				Approximate Interval Between Onset and Death
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60,	icate be executed physician and s the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a con-	GER	Ariza	Aft	fisces	2055	DYGARS
68760,		edicat	<u> </u>	d						
O. Box	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	□Ectopic pregnancy □ Other (specify) _	/		23d. Date of del Month	ivery Day Year
rds, P.	w requires that been signed by should be deta	ρ	Part II. Dther significant conditions of	ontributing to death but not	resulting in the I	underlying cause giv	ren in Part I.		use contribute to	the cause of death?
Vital Records,	The ate had page	Completed				<u> </u>		24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death ((
of	Phys this rat di	. To	1 ☐ Yes 2 ☐ No 27. Manper of Death	1 ☐ Inpatient 2 28a. Date of Injury	2 ER/Outpatie		Nursing Home	5 Residence d. Describe how inju		cify)
	nding I tth. : After e funer	ation	Natural 5 Pending 2 Accident investigation	(Month, Day Year	r) Injury	Wor	k? Yes 2 □ No		,	
Division	or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, st ecity)	treet, factory, office	28	Location (Street a City or Town, Stat		ural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Madical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	nination and/or in	ovestigation, in my o	pinion, death occurred	at the time, date an	d place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29d. Da	ate signed (Mont	h, Day, Year)
	-		· Illedes	M).		5	7-22609	A	COUST 1	10-2005
	3			completed cause of death (7 4 4 S	Print) AC	E BRANC	Col Rol o	Ven Bu	n, Day, Year) 10-7005t. mil Hd 21060
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 0	2005 32. Redistrar's Si	gnature	Goodi				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend. item 5 per fb 846 8-29-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Ne Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Rosanna Powell Craiq August 2005 8:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5712 McCormick Avenue Baltimore Rosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. So217-26N-0754 **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min. 1 M 2 X F -32-3056 Yrs Director 74 8/29/1930 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland neal of Health and Mental Hygiene.
ant: If Item 27 is marked other then "natural", or Items 23e or 28e-f ehow ury or other treamatic event, Ite Medical Early are numble ovent, Ite Medical Early are numble. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 ☐ No MD Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5712 McCormick Avenue Completed by Funeral 21237 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant 12 Xray Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Valentine Biemer Rosanna Feil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Anne Ramsey/daughter 5712 McCormick Avenue Rosedale, MD 21237 Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. Dulaney Valley Mem. 8/8/05 Timonium, MD 21. Signature of Funeral Source Mcensee 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue, Rosedale, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Emphysema **Physician** disease or condition resulting in death) 25 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed2 1 🗌 Yes 2. No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA daughter's 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 Tyes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours e Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the e 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 150760 AUSUST 5th, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C HARLES

31. Date filed (Month, Day, Year) AUG 1

WENG 6

0 2005

M.D

307.

LoThervill, MM

1407 YORK 121.

32. Regetrar's Signature

			_ For	State of Maryla	and / Depa	rtment of H	lealth and M	lental Hygi	ene	
			1 - State Registrar		Cen	tificate of	Death	Re	g. No.2 1 1 5	26102
П	Physici	an	Decedent's Name (First, Middle, Last,			//		2. Date of Death Month	Day Year	5. Time of Death
э	/Medic		Jame		Powe			August		3:00FM
н	Examin	er	4a. Facility Name (If not institution, give	1. 11 . 11	4,,	4b. City, Town, o	or Location of Death		4c. County of Death	1
Н	Euparal		5. Social Security Number 6. Sec	C Heights	rs. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day	9. Birth	olace (State or Foreign
н	Funeral Director		254-26-4044 10	M 2□F 7	9 Yrs.	Months Days	Hours Min.	March 8	Year) 26 G	ntry)
	pu ,		Usual Residence of Decedent	100	City, Town or Loc	-1				and Inside City Limits
	shov	5	10a. State 10b. County	100.						10d. Inside City Limits 1 es 2 □ No
	the N	Directo	10e. Street and Number		Balty	10f. Zip Code		10	g. Citizen of What Cou	
	72 hours after death with the Maryland naturel; or Items 23s or 28s-f show dical Exam ar must be mullied at	Ö		Heights.	Avenue		215		USA	7
	death	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. W		Hispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No-	14. Race · Ameri Black, White,	
õ	or Ite		1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	i	Yes 2000		riouri, oto.y	Specify: 12	A .
5-0036	be filed within 72 hours after that Hygiene. d other then "naturel, or levent, the Madical Exami	d by	3 ₩Widowed 4 □ Divorced	Year or Dates:	160 Doord	antia Haval Occur	nation	Ι.	13/9	ick
ر	in 72 "nat	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give k	ent's Usual Occup iind of work done O NOT use retired	during most of work	ing	6b. Kind of Business/In	dustry
212	filed within thygiene. other then "	m o	Elementary/Secondary (0-12)	College (1-4or 5+)		DRIVEY	i ·		Truu	kowa
פ	e filec at Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)		•		18. Mother's Name		laiden Sumame)	
<u> a</u>	should be nd Menta marked matic ev	To	Johnnie	Strong		-	Ani	nie Mi	anie Pou	1el/
Maryland	2 sho		19a. Informant's Name/Relationship (Ty	12 1	19b. Mailing	10:23		- 0.65	City or Town, State, Zip	
	s 1 and f Health Item 27 other to		Janie Brown 20a. Method of Disposition		703 D. Place of Dispos	Perrin S	Sylvere 16	TUE NU	oc. Location - City or To	130/1. MY212
Baltimore,	e = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crem	atory or otner piac	C O I .		Arbotos	
	Department Department mportent: any injury once.		 4 □ Donation 5 □ Other (Specify) 21. Signature of Fu era Servi Licens 							
Ba	permit. Departm Importe any inju) L++-	-		He.v. 1	Cluse	Fune	alltimore A	CX P.77
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the de	eath. Do not ente	r the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	The Cause of Feach line.	1, m	w n	5-0 L	Danie		Onset and Death
	/Medical		resulting in death)	Due to (or as a cons	sequence of):	A. chan	V-4-	1		
	Examiner		Sequentially list conditions.	, Others	Filmst	< Ca	ulimark	pro	400	
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):	D 8				
7	xecut and al-tran	хап	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	MALINE	u-e_			
8760	cate be executed oblysician and the burial-transit		l (Him	ulusi	0				
89	ifficate g phys as the	ledic		0,	•					
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	23b. was decedent pregnant	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy	v		23d. Date of deliv	
E	e dea the att	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of 9☐Unknown		Other (specify)	,		Month	Day Year
о. О	d by I	Phy	Part II. Other significant conditions con	atributing to death but not	resulting in the un	derlying cause an	on in Part I	23e Did toba	acco use contribute to t	he cause of death?
ds,	signe d be c	d by	Tarris digitilisani della di di	minus and a document of the control	ossing in the sin	dorlying odddo giv	TOTAL TOTAL	1 ☐ Yes		
Ö	w requir been si should	Completed						24a. Was an	24h Were auto	nev findings available
Ä	he fav e has ige 2	ошо						autopsy perform	ed? death?	ppsy findings available impletion of cause of
ta	ifficate or, pa	O	25. Was case referred to medical				26 Place of Death	1 Yes 2	No 1 ☐ Yes	2∐ No
<u>=</u>	ysicionis cer direct	To B	examiner? 1 Ves 2 No	lospital:	ER/Outpatient	3□ DOA Oth		me 5 Resider		(y)
0	ng Ph ter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injur Wor	ry at rk?	28d. Describe how	w injury occurred	
Sio	eath. or: A	catio	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No			
Division of Vital Records,	l or Att after d Direct d in by	ertification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre ecify)	et, factory, office		281. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	e Hospitel 24 hours e e Funerel letely filled	O	29a. Certifier 1 Certifying Phy	sician: To the best of my	cnowledge, death	occurred at the tir	me, date and place.	and due to the car	use(s) and manner as s	tated.
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Exami one)	ner: On the basis of exam and manner stated.	ination and/or inv	estigation, in my o	ppinion, death occurr	ed at the time, da	te and place, and due to	o the cause(s)
	To the within 2 To the complet	Me	295: Signature and title of certifier			29c. Licens		29	d. Date signed (Month,	Day, Year)
)	j		My my Me			\$ 30	0408		2010102	
	6			ompleted cause of death (I	tem 23a) (Type, F	Print)	. \		11113	
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	nature 56%	A mo	Pre W	. "\	2/177	
		1111		-77						

State Registrar

AUG 1 0 ZUUD DHMH 17 Rev 1/2001

32 Registrar's Signature

ORIGINAL

		1	For State Registrar	State o	of Marylan		artment of tificate of	Health and Macath		ene No 2005	26101
			Decedent's Name (First, Middle	, Last)					2. Date of Death Month	Day Yea	3. Time of Death
	Physicia		Arnold	C.	Prez	iotti			Aug. 2	2005 Yea	6:00 FM M
ı	/Medic Examin		4a. Facility Name (If not institution 5005 Doctorfi	_	imber)		4b. City, Town,	or Location of Death Waldorf		4c. County of De Charl	
	Funeral Director		5. Social Security Number 578-22-1661	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 82	last birthday) Yrs.	if Under 1 Yea Months Days		8. Date of Birth (Month, Day,) Feb. 21	9.8 1923 Ge	irthplace (State or Foreign Country) OTGIA
	D >		Usual Residence of Decedent 10a, State 10b, County		10c Cit	y, Town or La	cation				10d. Inside City Limits
	Aaryla F sho	ō	Maryland Charle) C			ldorf				1 ☐ Yes 2 📉 No
	28a-	Directo	10e. Street and Number	.0			10f. Zip Code		100	g. Citizen of What	
	h with	a D	5005 Doctor	fish Ct.			20603	3		U.S.A	
	ems	Funeral	11. Marital Status	Armed F	cedent Ever in U. orces?	.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	nencan Indian, nite, etc.
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marr X ☐ Widowed 4 ☐ Divorced	If Yes, G	2 □ No 194 ive Dates: 194		1□Yes 2√ N	o Specify:		Specify: W	hite
5-0036	2 hou	ted	15. Deceden	t's Education	1)	16a. Dece	dent's Usual Occ	upation le during most of work		3b. Kind of Busine	ss/Industry
21215	within 72 hours after death with the Maryland one. Than "natural", or items 23a or 28a-f show ha Me Jigal Ezatti nar must be notitied at	Completed	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	`life.	nd Engra	red)	9	Engravin	σ
N	filed w Hygier other th	Cor	12t h 17. Father's Name (First, Middle,	Last)		1110	IIIu Eligia		e (First, Middle, M		0
Maryland	d be fi	To Be	Charles Pro					Helen	Turi		
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merital Hygiane. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Exam are must be notified at anony injury or other traumatic event.	F	19a. Informant's Name/Relations					et and Number or Ru			
	1 and 2 Health a lem 27 is		Betty Jo Pre	ziotti (D	aughter)	5005	Doctorf	ish Ct. Wa	ldorf, Ma	aryland 2 Oc. Location - City	0603
ore	Pages 1		20a. Method of Disposition 1	3 Removal from	n State	cemetery, cre	nsition (Name of matory or other p	, ,	gust 9,		Maryland
Baltimore,	it. Paritimen ritant:		* 4 □ Donation 5 □ Other (S		Kes		cion Cem		2005 Lee Funer		
Ba	permit. Departr Imports any inj		1/1/1/19	1. Which	190015	53 6	6633 Old				ton, MD 20735
	1.0		23a. Part1. Enter the disease, of shock, or heart failure. List	r complications that only one cause on	caused the deal	th. Do not en	ter the mode of d	ying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	-a a	outs:	Fata	Cardi	ice HVY	lyth mia		3mm5
	/Medical Examiner		resulting in death)	Due to	o (or as a consec	quence of):	Pinana	. Orto	m Di	2	DOLLAN
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a cons	ence (x):	N VI TUR	7	1	,	To for
	outed od ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	S c							
, 00	ate be executed obysician and the burial-transit		resulting in death) Last	Due to	o (or as a consec	quence of):					
68760,	icate b physic s the b	Physician/Medical		d							
Box (leath certifical attending phy I for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		⊒Ectopic pregna	ncv		23d. Date of	
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (specify)			Month	Day Year
P.O.	± ≥ 5		9 Unknown Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	underlying cause	given in Part I.	23e. Did tob	acco use contribut	to the cause of death?
ds,	w requires that been signed to should be det	d by	Nm-Hodaku	is hym	Arma	, Est	-mi De	Silitz	1 ☐ Ye	s 2 No 3	Probably 4 Unknown
Vital Records,	taw req as beer 2 shou	Completed	of Frail for 0	Parkin-	5m'5	Dia ., 1	Fortic	Selerous	24a. Was ar		autopsy findin s available to completion of cause of
Re	o o	mo	+ 5+ w/151	5. Vas	endus	Din	entra		perform	ed? death	1?
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					Othon	ath (Check only one		
o	this al di	To	1 Yes 2 No 27. Manner of Death		Inpatient 2	ER/Outpatie	int 3 DOA	njury at Vork?	lome 5 Reside		pecify)
on	ing Affei une	tlon	1 Natural 5 ☐ Pendi	/4.4/	onth, Day Year)	Injury		Nork? □Yes 2□No			
Division	or Attendi after death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could	minor 280, Pla	ce of Injury - At h	nome, farm, s	treet, factory, office	СӨ	28f. Location (Str City or Town	eet and Number of State)	Rural Route Number,
Ö	spital or At ours after of heral Direct filled in by			Sheristan T.	<u> </u>		45	time data and place	and due to the co	uca(c) and manne	r as stated
	€ F P 0	edical	29a. Certifier 1 Certifyi (Check only 2 Medica	I Examiner: On the	the best of my kn i basis of examin anner stated.	ation and/or i	nvestigation, in m	e time, date and place ny opinion, death occu	arred at the time, da	ite and place, and	due to the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certific	er /	`	han	29c. Lice	ense number	29	d. Date signed (M	onth, Day, Year)
	L	1	1 Michail	16/11	men	111)		02237	mp	8/3/0.	>
1	0'/	1	30. Name and address of person					4202	Woldens	MD 2060	3
	St	ate	31 Date filed (Month, Day, Yea,	arson, M.	D. 10 S1. Registrar's Sign		TICKS Dr	ive, #203,	Waldoll	MD 2060	J
	Regist		AUG 1	0 20.05	Marie	15:	parti				

3			State of Maryland / Department of Health and Mental Hygiene 1- State Registre AMEND ITEM #10b-f PER FH C846 87 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
4	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
	/Medic Examir		4a. Facility Name (If not institution, give street and number) University Hospital 500 block Orchard Street Baltimore August 4, 2005 11:30 A 4c. County of Death N/A
No.	Funeral Director		5. Social Security Number 213-90-2667 CM 2 F 7. Age (In yrs. last birthday) 27 Yrs. Usual Residence of Decedent 1. Age (In yrs. last birthday) 27 Yrs. 1. Age (In yrs. last birthday) 27 Yrs. 1. Age (In yrs. last birthday) 3. Birthplace (State or Foreign (Month), Day, Year) 4. Age (In yrs. last birthday)
	he Maryland 28a-1 show cuilled at	Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE N/A GWYNN OAK BALTIMORE XXYes 27.No
	h with I		10e. Street and Number 622. MARKHAM ROAD 6523 WOODGREEN CIRCLE 10f. Zip Code 10g. Citizen of What Country? USA
036	hours after death with the Maryland tural', or Items 23a or 28a-1 show at Examinat must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 11. Never Married 2 Married 3 Widowed 4 Divorced 11. Yes 2 No Specify: 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Yes 2 No Specify: 16. Yes 2 No Specify: 17. Yes 2 No Specify: 18. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Yes 2 No Specify: 10. Yes 2 No Specify: 11. Yes 2 No Specify: 11. Yes 2 No Specify: 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.)
21215-0036	l within 72 iene. r than "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 2 TH 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER 16b. Kind of Business/Industry LABORER
pur (be filed htal Hygi od other event,	Be	12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Maryland	s 1 end 2 should I f Health and Meni Item 27 is marked other traumatic	2	MICHAEL ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	1 end 2 dealth a om 27 li		MICHAEL ROBINSON / FATHER 6523 WOODGREEN CIR., BALTIMORE, MD 21207
altimore,	Page net o int: If		**Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) **Cometery, crematory or other place) MT. ZION CEM. 8/12/05 BALTIMORE CO., MD
Ba	permit. Departn Imports any inju		21. Signatur Final Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207
	Physician /Medical Examiner	iner	23a. Paint: Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Due in (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause. Disease or injury
38760,	icate be executed physician and s the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last C
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
Δ.	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Vital Records,	The law ate has b pege 2 st	e Completed	24a. Was an autopsy findings available prior to completion of cause of death? 25. Was case referred to medical 26. Place of Death. Chark sales are 20 No.
	sir sir	To B	examiner? 1
Division of	After	Certification:	27. Manner ol Death 1 Natural 5 Pending (Month, Pay Year) 2 Accident investigation 3 Suicide 6 Could not be
Divi	Itel or At irs after or rel Directed in by		28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Add all Examiner: On the basis of oxal institution and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within 2 To the comple	2 /	29b. Signature and little of entidler 29c. License number 29d. Date signed (Month, Day, Year) August 07, 2005
Ψ	1		30. Name and address of person who completed cause oldedth (Item 23a) (Type, Print) The penn Street, Baltimore, Maryland 21201
	Sta Registr	is.	31. Date filed (Month, Day, Year) 32. Registrar's Signature

	•	For State Registrar			_	Cei	tificate					g. No.)	105	251	ηc
hysicia	n	1. Decedent's Name (First, Middle		Stefar	D_{mn}	Roman	Sr.				2. Date of Deat Month	Pay	Year	9-Time of Di	anth O
Medica amine		4a. Facility Name (If not institution,	give stree	t and numb	9r)		4b. City, T	Town, or	Location of	Death	08	4c. Cour	2005	1-"	100 101
mine		Long View Nu							heste	r		Ca	arroll		
ıl r		218-05-6685	6. Sex 1 ☐ M	2□ F 7.	Age (In yrs.	last birthday) Yrs.	if Under 1 Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day Dec. 20	Year) 1918	9. Birthpla	ice (State or F land	oreign
	2	Usual Residence of Decedent 10a. State 10b. County Md. Car:	roll		10c. City	y, Town or Lo Hamp	cation stead						10	d. Inside City	
	Funeral Director	10e. Street and Number 3916 Shiloh A	venue				10f. Zip (Code 1074			10	og. Citizen o	of What Count		
		11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. V		□No	1		ent of His fy Cubar	spanic Orig	in? (Spec Puerto F	cify Yes or No- lican, etc.)	14. R	ace - America lack, White, e	tc.	
	Completed by	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	grade cor	n <i>mpleted)</i> College (1-40	or 5+)	16a. Deced (Give life. L	kind of work OO NOT use	done di retired)	urina most		g	Heati	Business/Indi	Air	
(To Be Co	17. Father's Name (First, Middle, L Julius Rom							18. Mother	's Name	(First, Middle, M	taiden Suma		,	
		19a. Informant's Name/Relationsh Helen L. Ro		Print)		19b. Mailin 3916	g Address (Shil	(Street a	nd Number Venue	or Rural	Route Number, Hampste				
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		val from Sta	te c	lace of Dispo emetery, cren letro C	natory or oth	her place		Da	te 2		timore		
- Suce		21. Signature of units Service L	icensee	m		22	Name and Eckha	rdt	Funer	al C	hapel, Manches	P.A.	*d 2	1102	
	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b c d.	Due to (or	as a consequal as a consequence as a conse	ience d).		~ // (oni						
Lalan (Man	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 4	Live birth	ne of pregnal 2 Fetal at time of de	death 3	Ectopic pred Other (spec						ate of delivery	, ay Yea	ır
1	2	Part II, Other significant condition	utt	ting to death	n but not resu	ilting in the un	derlying cau	use giver	n in Part I.		23e. Did tob	~	ntribute to the 3 ☐ Probal	cause of deat	
	Completed	Diabetes Melli Coronary ar	tus	- ad Dise	ult o ase	nset		<u>-</u> -			24a. Was an autopsy perform		death?	y findings ava pletion of caus	ulable e of
Q	o ne	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospit	tal:				Other	1000		Check only one				
. ∐H	- 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga		a. Date of In (Month, I		ER/Outpatient 28b. Time of Injury		c. Injury	4 Nurs	28	e 5 🗌 Resider d. Describe hov				
September 1	ertification	3 Suicide 6 Could no 4 Homicide determin		e. Place of building,	Injury - At ho etc. (Specify	me, farm, stre	et, factory,	office		28	f. Location (Str. City or Town,	eet and Num State)	ber or Rural I	Route Number	;
	Medical	29a. Certifier (Check only one) Certifying 2 Medical E	xamıner: (n: To the be On the basis and manner	of examinati	vledge, death ion and/or inv	occurred at estigation, in	t the time	e, date and nion, death	place, an	d due to the car I at the time, da	use(s) and m	nanner as stat , and due to th	ed. ne cause(s)	
M	ž	29b. Signature and the of certifier	Care	iles	ive		29c. 1	License	number 90 1		29	d. Date sign	ed (Month, Da	y, Year)	
State	e	30. Name and address of person w DOCYACIAS V: 7 31. Date/filled (Month, Day, Year)	no comple aus	teno,	f death (Item	4111 20	Print) WER	Bec	kley	svill	Rd A	7 mps	tead,	Md210	17.4
State egistra	-	AUG 1 0	2005	Ace	eur s	b.	ade								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Tul 3/ 2005 Estelle Saul /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SunBridge Care Center E1kton Ceci1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | May 5, 1944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🖾 F Yrs. Pennsylvania 205-34-2770 61 Director Usual Residence of Decedent 10d. Inside City Limits Marylan 10a. State 10b. County 10c. City, Town or Location traumatic event, It e Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Ceci1 Chesapeake City the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 100 Grayson Avenue 21915 United States items 23e Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 XNo fYes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No ō Specify: Specify: Completed by 3 Widowed 4 Divorced Year or Dates: White *naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Paper and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Packer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wanda Penprano Joseph Turzanski ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph Turzanski/Brother Williamstown, NJ item 27 i 3760 Lake Avenue, other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of the important: If ite eny injury or of once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 【Donation 5 ☐ Other (Specify) -16-05 etro (nemalor 22. Name and Address of Facility 21. Signature of Funeral Service Lice AM 1232 MidValley Dr. Jessup, PA 18434 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Interstiti mon461 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy Diubetes melli 1 ☐ Yes 2 No 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the **Director:** 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospitel
within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ham Obenshain, ISI S. Schemia Are, (ecillon, md, 21913 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Bruce 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State Registrar 2005

Maryland 21215-0036

Baltimore,

	an	1. Decedent's Name (Fin	rst, Middle, La:		a	OTT ICCT TO			N	ate of Dear	Day	Year	3. Time of Death
/Medic	al	FRANCES		ROSE		CHUSSLER		ocation of Dea		UG.	6, 200)5 ty of Death	1843 P M
Examin	er	4a Eacility Name (If not FRANKLIN S				ROS	SEDALE				BAL	TIMOI	RE
Funeral Director		5. Social Security Numb		Sex 7. Ag 1 ☐ M 2 🔯 F	ge (In yrs. iast i 24	Month		If Under 24 Hr Hours Mir	s. 8. D	ate of Birth Month, Day 12-6-	1980	Cou	place (State or Foreign intry) IFORNIA
3 2		Usual Residence of Dec 10a. State 10t	b. County		10c. City, To	own or Location							10d. Inside City Limits
28a-f ehow notified at	ctor	MD	-	IMORE			RASPEB	BURG					1 □Yes ZXXNo
a or 28 Lbe no	Director	10e. Street and Number 5621 LE)AD		10f. 2	Zip Code 2	21206		1	0g. Citizen of	What Cou	•
me 23a	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S.	13. Was Dec		panic Origin? (Mexican, Pue	(Specify	res or No-	14. Ra	ace - Amer	ican Indian,
"natural", or iteme 23a or 28a-f ehov adigut Evandrar must be notified at	2	1X Never Married 3 ☐ Widowed 4 ☐		Armed Forces? 1 ☐ Yes 2X If Yes, Give Year or Dates:	No			Specify:	no ricar	1, 8(0.)	Speci	ack, White <i>ify:</i> W	n, etc. HITE
natur	eted	15. (Specify o	Decedent's E	ducation a de completed)	16	Sa. Decedent's Us (Give kind of	work done du	ion ring most of w	rorking		16b. Kind of I	Business/I	ndustry
iene.	Completed	Elementary/Secondar	ry (0-12)	Cottege (1-4or	5+)	life. DO NOT WAI	TRESS				RES'	TAURA	NT
a other	BeC	17. Father's Name (Firs	t, Middle, Last	')			1	8. Mother's N	ame (Firs	st, Middle,			
narked natice	70	ROBERT	J	-	JSSLER	9b. Mailing Addre	oce (Street an		NTHI		C.	(CRA	
If health and Meniar Hygiene. Item 27 Ie marked other then "natur other treumatic event, ILE MEJICAL		19a. Informant's Name ROBERT S		ER/ FATHEI		5621 LEI				MORE,		21206	
if or near			remation 3	☐Removal from State	сете	of Disposition (A stery, crematory of CREMAT	r other place)		Date 9-20	05	20c. Location		
important: If ite any injury or of once.		4 Donation 5 21. Signature of Funera			MEIR			of Facility C					•
impo eny i		100	-0	When	JA-	Ĭ.		O AVEN			EDALE,		21237
voicion		23a. Part1. Enter the d shock, or heart fa	lisease, or com	plications that cause									
		Immediate Cause (Fina		one cause on each i	ine.							ons	Approximate Interval Between Onset and Death
edical		Immediate Cause (Fina disease or condition resulting in death)		one cause on each l	ine.	Cocaine 1						ons	Interval Between
edical iminer	her	disease or condition resulting in death)	al	a. Narcotion Due to (or as	c and C	Cocaine]						ons	Interval Between
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ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. itam 27 is marked other then "natural", or Itams 23e or 28e-f show other traumetic event, the Medical Evarupat must be notified at	Completed	15. Decedent's Elementary/Secondary (0-12)	rade completed) ((Decedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired)	ing 16b. F	Kind of Business/Industry
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altimore, M rmit. Pages 1 and 2 partment of Health portent: If item 27: y Injury or other trr		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	20b. Place of D	Disposition (Name of crematory or other place)	Date 20c. L	ocation - City or Town, State
Baltimoi permit. Pages Department of Important: If i any Injury or o		21. Signature of Funer II Service Lice		22. Name and Address of Fadility 10.54 51.76 526		I bewiee P.A
		23a. Part1. Enter the disease, of conshock, or heart failure. List only	mplications that caused the death. Do no y one cause on each line.	enter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death
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18760, cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of) d.			
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ecords, P. law requires that as been signed b	þ	Part II. Other significant conditions	contributing to death but not resulting in t	the underlying cause given in Part I.		use contribute to the cause of death?
Division of Vital Records, or attanding Physician: The law requires taller death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? yes 2□ No
f Viti ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	Other	me 5 ☐ Residence	6 ∏Other (Specify)
E g aft		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	28a. Date of Injury (Month, Day Year) 28b. Tir	me of 28c. Injury at	28d. Describe how inju	
Division or Attain after dea after dea l Director d in by the	Certification;	3 ☐ Suicide 6	28e. Place of Injury - At home, farm building, etc. (Specify) For private dwelling	n, street, factory, office	28f. Location (Street a City or Town, Stat Baltimore (nd Number of Rural Route Number 19, 915 N. Carey Street City, Maryland
Divisio To the Hospital or Attandi within 24 hours after death To the Funaral Director: A completely filled in by the t	edical C		Physician: To the best of my knowledge,	death occurred at the time, date and place, for investigation, in my opinion, death occur		
To th within To th	Me	29b. Signature and the or certifier	1/1/1	29c. License number		ate signed (Month, Day, Year)
		30. Name and address of person wh	o completed cluse of death (Item 23a) (T	O.C.M.E.		1st 7, 2005
myr.		31. Date filed (Month, Day, Year)	10G AV		er, Baltimo	ore Maryland 21201
St Regist	ate rar	AUG 1 n 201	To the state of th	redi		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** 9:59 AM 6 2005 heodore /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 6104 Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Dat Drive IAC BET H 8. Date of Birth (Month, Day, Year) 3–18–20 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F Days Hours Min 219-01-1890 85 Yrs. Director Md. Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ir Items 23c or 28a-f show the primast be notified at 1X Yes 2 No Md. NA Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6104 Macbeth Drive 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Xes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is markad other then "naturel", or Iter 1 Never Married 2 Married Saltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2 ☐ No Specify: Specify. þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Chemist Water Dept. City of DHD 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Geroge Rosa Τ. Stanley, Sr. King 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 6104 Macbeth Drive, Baltimore, Md. Myrtle Brooks Stanley 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition parmit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Owings Mills, Md. Garrison Forest Veti 8-12-05 *4 □ Denation 5 □ Other (Specify) re of Funeral Service Lice 21. Signatu 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East HOL E. North Ave. Pag 1. Enter the disease, or complications that caused just death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirting, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** done months disease or condition resisting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of: Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1eva mar 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO0 55 035 Auxast 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

an

ORIGINAL

32. Registrar's Signature

Hallarman

31. Date filed (Month, Day, Year)

Lock Baven Blud, Batto, MD 21218

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe0051 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 8:50 PM 2005 Rozalia Surowiec August 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Middle River Ivy Hall Nursing Home Baltimore Date of Birth (Month, Day, 3/12/ Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 □ M 2 🖼 F Months Days Hours Min Belaruse Yrs. 69 216-41-1095 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 7No Md Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21215 6918 Marsue Drive Apt. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 ₩ Widowed 4 Divorced <u>USA</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helena Krusz Jan Szwedko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Md. 21220 418 Kosoak Rd. Miss Helena Polanska 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Bayview Crematory 8/11/05 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) Kaczorowski Funeral Home P.A. 21. Signature of Funeral Service License Folis Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lot Glioblastemer disease or condition resulting in death) Due to (or as a consequence of). Pon cy topenie Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury Dilla to (or as a conductionne of): 12 s a consequence that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Box 68760. P.O. | signed t Division of Vital Records, Deen has page certificate director this After this funeral of death. the To the Hospitel or Attend within 24 hours after death To the Funerel Director: ģ

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

2

Examiner

Physician/Medical

by

Completed

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Certification:

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29a. Certifier

(Check only one)

Funeral

Director

2 should be filed within 72 hours after death with the Marylan and Mantal Hygiene. I be marked other than "naturel", or Items 23s or 28s-1 show rounsite years! The Marked Frainier mante and lined and the modified and the modifi

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be nent of Health and Mental

item 27 I

permit. Pages 1 Department of H Importent: If ite any injury or ot once.

Physician

Examiner

/Medical

State Registrar 29b. Signature and title of certifier

29c. License number 031467

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

BALSO MD. 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ShearbA. M.D. BZI N. ENTAW St. SciTE 308 HASHMI

and manner stated

31. Date filed (Month, Day, Year) 33. Da 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 8, 2005 ear **Physician** 4:12 P.M. Connie Ray Triplett /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 2632 Dulany St. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

March 26,1937 North Carolin 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Hours Months Days XXM 2 F Yrs. 68 224-52-9303 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County ral', or items 23a or 28a-f show Examiner must be notified at XXYes 2 □ No Completed by Funeral Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21223 e filed within 72 hours after death val Hygiene.
othar than "natural", or Items 23s 2632 Dulany 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes A No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: White 3√Vidowed 4 □ Divorced ar than "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Laundry Custodian 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic avent 9068. Mary Francis Baumgarner Jonah Rufus Triplett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brenda Lynn Gonzalez/Daughter 2632 Dulany St. Baltimore, MD 21223 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition south Fork Baptist XXBurial 2 Cremation 3 Removal from State 8/14/05 Piney Creek, N.C. Church Cemetery | 0/17/00 | 122. Name and Address of Facility Eckhardt Funeral Chapel P.A. * 4 □ Donation 5 Other (Specify) 21. Signature of Fune al Septice License 11605 Reisterstown Rd. Owings Mills, MD21117 ungs Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDIGI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner OROWARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Iding physician Box 68760 Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Month Year Dav Ь in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ ALUVE 1 Pes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 - No 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funaral Di 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 36336 Are #300 Bolomore MO ZIZS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 3449 KUMA REDERICL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Year **Physician** August 4, 0136 Diana Ivon Vidal /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air
If Under 1 Year If Under 24 Hrs. Upper Chesapeake Medical Center Harford 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1□M 2□F 104-40-2001 55 Director 19, 1949 Puerto Rico Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "nature!, or items 23a or 28a-f ehour the Medical Examiner must be notified at Md. Baltimore Middle River 1 ☐ Yes 2 ☑ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9805 Tailspin Lane 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years is 1 and 2 should be filed voil Health and Mentel Hygie. Item 27 is marked other the financial advisor healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cesar Vidal Hortensia Sampayo ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Bonilla-Dodson/daughter 9805 Tailspin Lane, Apt. J, Middle River, Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Depertment of H Important: if Ite eny injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 8/8/2005 Baltimore, Md. permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition i durchiz **Physician** Youadie resulting in death) /Medical Due to (or as a consequence of) Examiner Faule Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed inteter Mellitus Due to (or as a consequence of) ettending physiclen for use as the buris Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 4 Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypothy voidism, Porpher 1 Yes 2 No 3 Probably 4 Unknown Hypercholestrolina 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation ofter death Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide on 24 hours.
The Funerel Directory filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 th e 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 81412005 U0059387 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aly Natio, MO 2 Colante Dr. Suite

State Registrar

0 2005

Nagaib, MO

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2 Colgate

203

Forest Hill

Baltimore, Maryland 21215-0036

Box 68760.

Records, P.O.

Division of Vital

			For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	rtment of Hetificate of L		ental Hygien	000	26114
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	/Medic Examin		4a. Facility Name (If not institution, give		Wellness G	4b. City, Town, or		40	c. County of Death	1
	Funeral Director		5. Social Security Number 6. Se		(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year Sept. 8, 1	9. Birth Cou 928 Long	nplace (State or Foreign untry) VIEW WA
	show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 【☐ No
	with the Miss or 28a-f	Director	Maryland Montgom 10e. Street and Number 3146 Gracefield R		Sil	ver Sprin 10f. Zip Code 20904	18	10g. C	itizen of What Cor U.S.A.	
36	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or items 23a or 28a-f show event, I're Madical Extrainer count be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ⅓ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ∑Yes 2 □ N If Yes, Give Year or Dates:	。1951- '	Vas Decedent of Hi Yes, specify Cubar □ Yes 2☑ No	spanic Origin? (Spec n, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Amer Black, White Specify: W	
Maryland 21215-0036	within 72 hou ene. than "natura ne Manical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 2		(Give	lent's Usual Occupa kind of work done of DO NOT use retired, IDUTET Pro	luring most of workin	g	Kind of Business/I	ndustry
land 2	12 should be filed within "n and Mental Hygiene." r is marked other than "r raumatic evant, the Mar	To Be Co	17. Father's Name (First, Middle, Last) Guy Carr	011			Mina	(First, Middle, Maide Hughes		ш.
Mary	ind 2 shou alth and M 27 is mar ar traumat		19a. Informant's Name/Relationship (7 Gwen Van Slyke (W	iype, Print) ife)	19b. Mailin 3146	g Address (Street a Gracefie	nd Number or Rural eld Road S	Route Number, City Silver Spr	or Town, State, Z ing, MD	_{їр Соде)} #416 20904
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked ery Injury or other traumatic es <u>once.</u>		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify		20b. Place of Dispo cemetery, crem Ft. Linco	natory or other place	Aug.	10.	ntwood,	
Balti	permit. Departn Imports eny Inju		21. Signature of Funeral Service Cice	2 400	153 6	Name and Addres	lexandria	Funeral Ferry Ro	•	c. on, MD20735
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.O. Box 68	The law requires that the death certificate be executed ate been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
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Vital	Physician: This certificatral director, p	o Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	nt 2 ER/Outpatier	it 3 DOA Othe	26. Place of Death	(Check only one) ne 5 ☐ Residence	6 □Other (Spec	eify)
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical			examination and/or in	vestigation, in my of	pinion, death occurre	d at the time, date a	nd place, and due	to the cause(s)
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4	XVI		30. Name and address of person who	YYAD, M	NO 1579	Mali G	Center D	Rockins	re, MO	20850
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1- State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene
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Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** August 4, VYSHNEVSKY 01:57 a M SERGEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Route 50 @ Dominion Road Queen Anne's Chester ## Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | FEB . 22, 1969 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1**X** M 2□ F 36 ÜKRAINE Yrs. 219-39-7321 Director Usual Residence of Decedent 10c. City, Town or Location or 28a-f show 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Directo BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? in than "natural", or iteme 23s or the Medical Examinar must be 13 SUNTOP COURT #302 21209 UKRAINE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Colfege (1-4or 5+) DRIVER LIVERY 27 is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SEMEN VYSHNEVSKY NINA VYSHNEVSKAYA 2 19a. Informant's Name/Relationship (Type, Print)

OLGA Wishneyskaya WI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 VOKZALNAYA STREET #104 - BUCHA, UKRAINE 08292 WIFE item 2 20a. Method of Disposition
1 ☐ Burial 2 🗖 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Depertment of Important: If it any injury or o HILLTOP SERVICE CORP. 08/09/2005 4 □Donation 5 □ Other (Specify) TOWSON, MD 22. Name and Address of Facility 21. Signature que uneral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine inding physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of defivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown certificete has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💋 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗆 No Yes 2 🗆 No Hospitei or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify at SCENE ™Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After the funeral 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending death. 2 Accident investigation 1 Yes within 24 hours after death To the Funerel Director: / completely filled in by the f OIY3 Hona 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 4, 2005 M. neus 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 31. Date filed (Month, Day, Year)

State Registrar

AUG 1 0 2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Wostulewicz KAthleen

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		_	- State Registrar			Certificate of	Death		Reg. No 0 0	5 26117
ı	Physici /Medic		1. Decedent's Name (First, Middle, La Kathleen M. Wojtu	•				2. Date of De. Month	Day \	3. Time of Death
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	2 should be filed within 72 hours aftar deeth with the Maryland and Mantal Hygiene. Is marked other than "netural, or Items 23a or 28e-f show eumatic event, the Modreal Examiner must be marified at	i Dir	341 Chimney Oak Drive	9		10f. Zip Code 21.085			10g. Citizen of Wh	at Country?
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	りにてき		Adam J Wojtulewicz		341	Chimney Oak	Drive Jop	pa, Md. 21	085	
altimore,	permit. Pages 1 and Department of Heall Important: If item 2 eny injury or other Once.		20a. Method of Disposition 1 ☐ Burial XXI Cremation 3 ☐	Removal from State	cemetery	Disposition (Name of r, crematory or other place Crematory Inc	August 5	Date	20c. Location - Ci Baltimore,	
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2	el or Attend s after death it Director: /	Certification:	4 Homicide determined		- At nome, fan Specify)	m, street, factory, office		28f. Location (S City or Tow	itreet and Number m, State)	or Rural Route Number,
	e Hospitel or A 24 hours after e Funerel Direct letely filled in by	Medical C	Check only 2 Medical Exal	nysician: To the best of miner: On the basis of ex	amination and	death occurred at the tir for investigation, in my o	ne, date and place	e, and due to the durred at the time.	cause(s) and mann date and place, and	er as stated.
	To the Hosp within 24 ho To the Fune completely f	Med	29b. Signature and title of certifier	and manner stated		29c. Licens			29d. Daye signed (i	
			N XX			1700	52624		8/4/05	

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tames A. Wellow Do. 9000 Franklin Square Dr. Bultimore NO 71237

31. Date filed Month, Day, Year)

AUG 1 0 2005 | Market M. April

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician LATONIA M. WRIGHT 2200 /Medical July 31, 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MERCY HOSPITAL BALTIMORE
Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 F Director 212 98 7869 AUG.20,1980 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show Examiner must be notified at 1_Yes 2 No Director BALTIMORE **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a Funeral 1217 SUGARWOOD CIRCLE U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 💢 Yo Specify: Specify: BLACK þ 3 Widowed 4 Divorced Year or Dates: neturel Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME year HOUSEWIFE other other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) mit. Pages 1 and 2 should be filt pertment of Health and Mental Hyportent: If item 27 is marked oth y injury or other treumetic even JAMES WRIGHT 0 DAISY DUDLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERALD ERVIN (HUSBAND) 1217 SUGARWOOD CIRCLE, ESSEX, ND. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Denation 5 Other (Specify) KING MEMORIAL PARK AUG.8, 2005 RANDALLSTOWN, MD. permit.
Deporte
Importe
any inju 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 F. PRESTON ST. BALITO, MD. ure of Funeral Service Licensee 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS HRS /Medical Due to (or as a consequence of): **Examiner** GALLSTONE PANCREATITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HES Examiner Due to (or as a consequence of) Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Year Day 5 Other (specify) 4 Pregnant at time of death ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes s after deau...
rel Director: After this co.....
in by the funeral director, pe 1 ☐ Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo Certification: To 1 Minpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1XX Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar DHMH 17 Rev 1/2001

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JUSTAN COSTA 31. Date filed (Month, Day, Year)

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PAUL PLACE

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

San Belle

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BACT WORE, MD

31, 2005

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			For State Registrar	State of Marylan	-	artment tificate				iene	05	26119	3
	Physicia	an	Decedent's Name (First, Middle, Last) Ruth	Е.	Wi	lson			2. Date of Deal Month		Year 2005	3. Time of Death 5:36a	h M
	/Medic Examin	-	4a. Facility Name (If not institution, give s	treet and number)			own, or Loc	ation of Death			unty of Deat		
			608 Barlett Aven	iue				more			NΑ		
	Funeral Director		5. Social Security Number 6. Sex 216-28-2351	м ж 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Months		Under 24 Hrs. ours Min.	8. Date of Birth (Month Day)	34 ^{r)}	9. Birti	nplace (State or Fore untry) Md.	əign
	yland Now		10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Lim	nits
	e Mar ta-fsh	Director	Md. N.	A	Baltim	ore						1 (X Yes 2 ☐	No
	with th	Dire	10e. Street and Number			10f. Zip C	ode 21218		1	•	of What Co JSA	untry?	
	leath v	Funeral	608 Bartlett Ave	12 Was Decedent Ever in II	.S. 13.1			nic Origin? (S	pecify Yes or No-		Race - Ame	rican Indian.	
980	d within 72 hours after death with the Maryland Jiene r than "natural", or flems 23a or 28a-f show Itte Modeal Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		fYes, specify 1 ☐ Yes 2			pecify Yes or No- p Rican, etc.)		Black, White		
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual	Occupation	n na most of wor	kina	16b. Kind	of Business/	Industry	
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		oo NOT use achine		ng most of wor		Bec	kton 1	Dickerson	
d 2	in, in the	မ င	8th grade 17. Father's Name (First, Middle, Last)		l I	actime			ne (First, Middle,			Dickerbon	
Maryland 21215-0036		To B	Joseph		ggold			Gladys			Lar		
Mar	2 m m		19a. Informant's Name/Relationship (Type Earle S. Wilson	_{ов, Print)} Husband					rai Route Number Baltimor			Tip Code) 1218	
	s 1 and f Health itam 27 other tr		20a. Method of Disposition	20b. F	_ Place of Dispo cemetery, crea				-		ion - City or	Town, State	
Baltimore,	Pages nent of int: If its ury or o		1 🎇 Burial 2 □ Cremation 3 □ Re 1 💆 Donation 5 □ Other (Specify)	dinovalitori State				et. 8-	11-05	Ow	ings	Mills, M	d.
3alti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License			2. Name and			Balti	more		21202	
ш	g ∪ ≅ g ol		23a. Part1. Enter the disease, or compli	would be dead	Do not ont			I. East			North	Ave. Approximate	- 1
	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.								Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consec	juence of):	-l .	Cala		Corcin				
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	uence of):	JIC	OK	on '	DYCIN	Sho			
	death certificate be executed e attending physician and ind for use as the burial-transit	Examine	that initiated events										
8760,	be exe cian a burial-	al Ex	resulting in death) Last	Due to (or as a conseq	uence of):								
687	tificate I g physi as the b	edical	d										
Box (ath certif attending for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna		7e-	curan			23d	. Date of del	ivery	
	e death he atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 D No	1 Live birth 2 ☐ Feta 4 Pregnant at time of c 9 Unknown		Ectopic pred Other (spec					Month	Day Year	
P.0	that the de ed by the detached		9 ☐ Unknowfi Part II. Other significant conditions con	stributing to death but not res	sulting in the u	nderlving cau	use aiven in	n Part I.	23e. Did to	bacco use	contribute to	the cause of death?	?
Records,	se og	ed by							1 🗆 Y	es 2	lo 3⊟Pr	obabiy 4 ∐Unkno	own
900	e law requir has been si je 2 should	Completed							24a. Was a	an 2	4b. Were au	topsy findings availa	able
- R	(G)	Com							perfor	med? 2 X No	death?	2□ No	Oi
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			Othor	_	th (Check only or				
of		To :	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o		c. Injury at	4 Nursing H	ome 5 K Resid 28d. Describe h			cify)	-
ion	Attanding Phy r death. actor: After thi by the funeral o	atior	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes	2 🗆 No					
Division	l or Attane after deatl Diractor: I in by the	Certification;	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	reet, factory,	office		28f. Location (S City or Tow		lumber or Ru	ıral Route Number,	
	Hospita 4 hours Funeral	edical C	29a. Certifier Check only one) Check only	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at vestigation, i	t the time, o	date and place on, death occu	, and due to the d rred at the time, d	ause(s) an	d manner as ace, and due	stated. to the cause(s)	
	To the within 2 To the complet	Мес	29b. Signature and title of certifier	^		29c.	License nu	ımber		29d. Date s	igned (Mont	h, Day, Year)	
		_	Marui J.	Tel Duron	un		0	1793	30	Aug	3 tozu	7, 2005	•
1	ol.	2	30. Name and address of person who co	empleted cause of death (Itel	n 23a) (Type,	Print)	2110	77	Q-11	700	nva	MTD	100
	<u>ر</u>		31. Date filed (Month, Day, Year)	32. Regis ar's Sign	ature 1	MILIC	- Ht) (1	Tall	(11)	UIE	11100	20
	Sta Regist	ate rar	AUG 1 0		, St.	Good							

			For State Registrar	State of Marylan		artment or rtificate			ınd M	ental H	lygien Reg. N	0000	26	120
	Physici	an	1. Decedent's Name (First, Middle, Las THOMAS BRUCE Y	,						2. Date of I Month	0	ay Year	3. Tir	ne of Death 48 P M
	/Medic Examin		4a. Facility Name (If not institution, give WASHINGTON COU	street and number)		4b. City, To		Location o	f Death	JULT Z		c. County of De		
	Funeral Director		5. Social Security Number 6. Se 232-84-1833	9x 7. Age (<i>In yr</i> s. 54	last birthday) Yrs.	If Under 1 Months D	Year Days	If Under 2 Hours	Min.	8. Date of Month, MARCH	Birth Day, Yea 14, 19	9. B 951 WES	irthplace (St Sountry) ST VIRG	tate or Foreign INIA
	<u> </u>		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation								de City Limits
	he Man 28a-f sh cuiffed	Director	WV JEFFER	SON	SHE	PHERDS		IN			100.0	itizen of What (Yes 2X□No
	th with t	al Dir	84 RED BLOSSOM	CIRCLE			5443				log. (USA	Journay?	
036	72 hours after death with the Maryland natural, or items 23a or 28a-f show disal Evanher must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ Xo If Yes, Give X Year or Dates:		Was Deceder If Yes, specify 1 ☐ Yes 202		panic Orig , Mexican Specify:	gin? (Spe , Puerto l	cify Yes or Rican, etc.)	No-	14. Race - An Black, Wh Specify:		
21215-003	be filed within 72 hours after death with the Marylan Hygione. d chlygione. d other than "natural", or items 23a or 28a-f show event, I'm Medical Evander must be rediffed at	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+) 5+	(Give life.	dent's Usual (kind of work DO NOT use DUNDER	done du retired)	uring most			16b. G	Kind of Busines _ COMMUNI(s/Industry CATIONS	INC.
Maryland	should be filed nd Mental Hyg i marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) WOODROW W. YOS	Т				KA'	THRY	N HUDS	SON	en Surname)		
Mar	a de la serie		19a. Informant's Name/Relationship (7									or Town, State, STOWN,		443
altimore,	nit, Pages 1 and criment of Healt ortant: If item 2' injury or other?		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removariioni State	Place of Dispo emetery, crer MWOOD	CEMETE	ERY	1	AUGUS	5	SH	Location - City of IEPHERDS	TOWN,	WV
Balt	permit, Pag Depertment Important: any njury once		21. Signature of Funeral Service Licen	See (Carrage)	22	BROWN F	Addless UNER	AL HOW	YE, P. MAR	O. BOX	821,	327 W. K. / 25402	ING ST.	,
	Inysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or companies, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	Due to (or as a conseq	uence of):	fent s	of dying Stap 24u 24u	hylo	COCC	r respiratory	rarrest, Illu Jufft	ctouch solsis	Interva	dinate il Between and eath
8760,	icate be executed physician and s the burial-transit	Icai	that initiated events resulting in death) Last	d. Allagyneic	t '	ue Me	711	00	to	msb	lar	+	6	years
O. Box 6	Attending Physician: The law requires that the death certificate be executed to death. The certificate has been signed by the attending physician and ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic preg Other (spec					-	23d. Date of d Month	elivery Day	Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions of Hypeqly Co	1	ulting in the u	nderlying cau	ise give	n in Part I.			d tobacco	o use contribute 2⊠No 3□I		e of death? 4 □Unknown
Il Records,	: The law re cate has bee page 2 sho	Completed				-				24a. W au pe 1 🗆 Yes	itopsy informed?	prior to death	completion	ings available of cause of
Z Zita	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: patient 2 🗆	ER/Outpatier	nt 3 DOA	Othe	r.		<i>(Check oni</i> ne 5⊟Re		6 □Other (Sp	necify)	
o uo	iding Physin. Ih.: After this funeral di		27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 280	injury Work	at ? 'es 2 🗀 I	4.	28d. Describ	e how in	jury occurred		
Division of Vital	2 € € €	ertification:	3 Suicide 6 Could not be determined		ome, farm, str	reet, factory, o	office		2		n (Strøøt Town, Sta	and Number or i	Rural Route	Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, deat tion and/or in	h occurred at vestigation, in	the time	e, date an inion, dea	d place, a	and due to the	he cause ne, date a	(s) and manner nd place, and d	as stated. ue to the cau	use(s)
	To the comple	Z	29b. Signature and title of certifier	anda	- W/C	29c. l	License	number	72)	29d. [Date signed (Mo.	nth, Day, Ye	mar)
11	5/		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,	Print)	121	0 6	100	1 0	, ,	Horas	House	21740
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	11)	1)		2717		11	Hade	WIGWI	
	Registi	वा	nou .	LU 4UUJ Flora.	1 1 M	ana	200 1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician August 5 2005 Year Elizabeth Margaret Antonelli 2:34 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Brightview Assisted Living Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5/17/1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ☐ M 2 🂢 F 220-18-5433 79 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits or 28a-f show traumatic svent, the Medical Examinar must be notified at MD Baltimore Monkton 1 ☐¥es 21 No Directo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21111 Items 23e 1728 Monkton Farms Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after o Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or item any injury or other traumatic svent, the Mudical Evantment once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Communications Telephone Operator 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Graham Grace Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph Barry Antonelli/son 1728 Monkton Farms Dr., Monkton MD 21111 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 8/12/2005 Baltimore, MD LOUDON PARK CEMETERY Donation & Other (Specify) Mausoleum 22. Name and Address of Facility Singleton Funeral Home P.A. M01364 1 Second Ave SW Glen Burnie MD 21061 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Box 68760 Physician/Medical g phy: IF FEMALE: BSD If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an this certificate has autopsy Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other 4 Nursing Home 5 Residence 6 KOther (Specify) Livin 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospitel or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral is per of Death Date of Injury (Month, Day Year) 28c. 28d. Describe how injury occurred Certification; 1 Accident 5 Pending investigation 1 🗌 Yes 2 No 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Ty 31. Date filed (Month, Day, Year) State AUG 1 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Year Month Physician George T. Alder 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE PANES HEALTHCAVE TUILA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 15 M 2 □ F 220-12-6779 11, Maryland Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b Counts ?7 is marked other then "natural", or itema 23a or 28a-f ehow traumatic event, the Madical Exampler trunk to notified at 1 Yes 2X No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 207 S. Rolling Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (⊋Yes 2 □ No If Yes, Give WWII Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after clent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural; or Iter 1 Never Married 2 4 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Defense Industry Project Expediter 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Benjamin Howard Alder Hattie Elizabeth Millenburg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a important: if item 27 is eny injury or other tret once. Caroline Alder Wife 207 S. Rolling Road; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Mem.Garden 8/12/2005 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, Inc.
736 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Fun ral Service, Ce Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final arcula LYUS C Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 🗆 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X 1 to 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide after within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Angust 9, 2005 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)
AUG 1 1 2005

SNIGH ESPOSIT

82. Registrar's Signature

900 Caton Arnue

DHMH 17 Rev 1/2001

Baltmore Maryland

05-05343 eorge Buggs RJD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 8, Da 2005 Year 0315 A. **Physician** Lee Buggs George /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3035 Grayson Street Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex.. 1 ⊈ M 2 ☐ F 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 123-56-3118 March 12, 1974 Queens, Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County rai', or items 23a or 28a-f show Exeminer must be notified at 1 X Yes 2 No Director MD Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 3035 Grayson Street 21216 U. S. A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after X Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: Black intal Hygiene. led other than "natural", c sevent, the Medical Exer þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) Carpenter/Self Employed Construction 4years College 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental H 27 Is marked of traumatic svei Selissa Kinder 2 George Lee Buggs, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Itam 27 Is sny injury or other trau once. 92 Wahl Avenue, Inwood, New York 11096 Dr. Jeremian C. Gaffney/F.Dir. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Greenfield Cemetery 15Aug. 105 Hempstead, NY 4 ☐ Donation 5 ☐ Other (Specify) Latney's Funeral Home 21. Signure pl Funeral Service Licensee 22. Name and Address of Facility 3831 Georgia Avenue, N. W. Wash.D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Multiple Sharp Force Injuries Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed ding physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 □ Yes 2 □ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 🗖 No 24b. Were autopsy lindings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an autopsy performed: 1 Yes 2 No this certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) (Scene) Certification: To 1X Yes 2 No After thi 28a. Date of Injury
— (Month, Day Year) 28b. Time of Injury Friend 3:05 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death blubject assaulted with 1 Natural 5 Pending 1 ☐ Yes 2 ☐No s after death. I Director: Aft d in by the fur Knife investigation 2 🗌 Accident 3 Suicide 4 Homicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 3035 (SVRY SON ST Baltumer 14) 6 Could not be determined To the Hospital or Atte within 24 hours after dea To the Funeral Director completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Resource 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) State Registrar

f Hallau

O.C.M.E.

29d. Date signed (Month, Day, Year) August 8, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn St., Baltimore Maryland 21201

32. Registrar's Signature

			1 - For State Registrar	State of Ma	arylan		artmen rtificat					iene g. N ₂ ? (105	26121
	Physici		Decedent's Name (First, Middle, Las JOHN BUR	NETT	_						2. Date of Death Month August		2005	3. Time of Death
	/Medio Examir	er	4a. Facility Name (If not institution, give t Thomas Moore Nur				Hya	ttsv				T-	unty of Death	1000 A
1	Funeral Director		5. Social Security Number 6. Se 578-01-8457 x V	x 7. Ag ☐M 2☐F	e (In yrs. 94	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day, April 1	1 19:	Coun	lace (State or Foreign try) a SC
	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23a or 28e-f ahow Ita Madical Examirer must be notified at	Funeral Director	10a. State 10b. County MD PG 10e. Street and Number			y, Town or Lo					10	o. Citizen	of What Cour	0d. Inside City Limits 1 Yes 2 No
	ath with	ral Di	10015 Goldenwoo	d Ct				20772	2			-	5.A.	, .
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene Important: If item 27 is marked other than "naturel", or iteme 23a or 28e-f ahow any injury or other treumatic event, the Medical Examinet must be notified at ODGs.	d by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Was Decec f Yes, spec 1 ☐ Yes	cify Cubai	spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ^{ecify:} Blac	etc.
21215-0036	i within 72 h iene. r than "natu ire Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		+)	life. I	dent's Usua kind of wo. DO NOT us nitur	rk done d se retired)	uring mosi		ing		of Business/Ind	dustry
Maryland	ould be filed Mental Hyg warked other	To Be C	17. Father's Name (First, Middle, Last) John Burnett Sr						Pear	rly 1	(First, Middle, N Burnett	laiden Sun	пате)	
Mar	nd 2 sh alth and 27 ie m ir treum		19a. Informant's Name/Relationship (T. Joann Burnett	ype, Print)							d Route Number, Upper Ma			Code) 20772
altimore,	Pages 1 and the mant of Head ant: if item		20a. Method of Disposition Burial 2 Cremation 3 1 '4 Donation 5 Other (Specify,		C	lace of Dispo emetery, cren Linco	sition (Nan	ne of ther place	a)	D	Date 2	0c. Locati	on - City or To	
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8760,	Physician /Medical Examiner on the private personner of the private of the privat	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart fature. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		cath a conseq ensic a conseq	rosclo uence of): on uence of):					ular Dis			Approximate Interval Between Onset and Death
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rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death bi	ut not resu	ulting in the ur	nderlying c	ause give	n in Part I.					e cause of death?
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of Vi	Physicien: r this certific ral director,	To B	eyaminer?	Hospital: 1 🗌 Inpatie	nt 2 🗆	ER/Outpatien	t 3 🗆 DO	A Othe	r		(Check only one ne 5 ☐ Resider		Other (Specify	·)
Division o	ding h. After fune	Certification:	27. Manner of Death 1 Natural 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	i Year)	28b. Time of Injury	М		at ? es 2 □ î		28d. Describe hov	v injury oc	curred	
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	To the Hospital or A within 24 hours after To the Funerei Dire completely filled in b	Medical	one)	sician: To the best oner: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, a th occurre	and due to the car ad at the time, da	use(s) and te and plac	manner as sta	ated. the cause(s)
ļ	To With	2	29b. Signature and title of certifier	12/	Di	w		D002					gned <i>(Month, L</i> t 8 201	,
	37		30. Name and address of person who compersaild Zonoza			1 23a) (Type, uthern	Print)			MD 3				-
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			Sta - State Registrer	te of Maryland / Depa		nd Mental Hyg	giene	20125
			Decedent's Name (First, Middle, Last)		runcate or Death	2. Date of Dea Month		3. Time of Death
	Physici /Medio		CARL BRAWNE			08	ON 2005	
	Examir	er	4a. Facility Name (If not institution, give street a BAYVIEW MEDICAL	- CENTER	4b. City, Town, or Location of BALTIMORE	Death	BALTIN	
	Funeral Director		5. Social Security Number 6. Sex 1215-20-9981 123 M 25	7. Age (In yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	8. Date of Birth Min. (Month, Day Feb. 9,	9. Birtl	nplace (State or Foreign untry) yland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	a-f sho	ctor	Maryland N/A	Baltim	ore			M∏Yes 2 □ No
	th with the 23e or 28	Funeral Director	10e. Street and Number 3661 Malden Avenue		10f. Zip Code 21211		Og. Citizen of What Co USA	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. mportant: If item 27 is marked other then "neturel", or Items 23e or 28e-f show my injury or other traumatic event, it is Medical Examinar; unallocational page.	by	1 ☐ Never Married 2 ☐ Married 1 ☐	Yes 2 □ No	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2☐xNo Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
21215-0036	d within 72 ho jiene. r than "natur Itiu Medical	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Col	(Give life.	dent's Usual Occupation kind of work done during most DO NOT use retired) reer Army Retir	of working red	16b. Kind of Business/ United Stat	•
pu	be filed tal Hyg d othe evant,	Be	17. Father's Name (First, Middle, Last)		18. Mother	's Name (First, Middle,	Maiden Surname)	
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	1 and 2 s Health an am 27 is thar trau		Eva G. Brawner Wife		1 Malden Avenue			
Baltimore,	Pages 1 and of He Int: If Itam		20a. Method of Disposition 1 □ Buriał 2X Cremation 3 □ Remova	I II OIII State	osition (Name of matory or other place)	Date /10/05	20c. Location - City or	
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Ä	permi Depar Impor any ir	li ilg	Dym B. Al	nss 3	Name and Address of Facility Urgee—Henss—Se 631 Falls Road	ltz funeral Baltimore	Home, Inc. Maryland	21211
	Physician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not ent e on each line.	er the mode of dying, such as c	ardiac or respiratory arr	est,	Approximate Interval Between Onset and Death
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P.O. Box 6	or Attending Physician: The law requires that the death certificate be executed itter death. Director: After this certificate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	in the past 12 months?		Dectopic pregnancy Other (specify)		23d. Date of deli- Month	very Day Year
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Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, strubuilding, etc. (Specify)	eet, factory, office	28f. Location (SI City or Town	reet and Number or Rui n, State)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	(Check only 2 Medical Examinar: On	To the best of my knowledge, death the basis of examination and/or invidenance stated.	vestigation, in my opinion, death	occurred at the time, d	ate and place, and due	to the cause(s)
	withi To t	Σ	29b. Signature and title of certifier		29c. License number	2	9d. Date signed (Month	, Day, Year)
,	at 1		30. Name and address of person who completes	cause of death (Item 23a) (Type	H1-2-66 40	100 D416	8/8/0	21224
1	00		KUBERT DUH,	ANEY 49	29c. License number AF 766 46 Print) Print) PASTET	RNAVE.	BALTIMO	Re, MD
	Sta Registr		31. Date filed (Month, Day, Year) NUG 1 1 2005	32. Redistrar's Signature	goards)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** BRADPIE 0625 UANITA /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Lecation of Death County of Death Examiner Genea owar olumbia 5. Social Security Number 6. Sex (In yrs. last birthday) 1 Year **Funeral** Days 115-28-387 1□ M 2 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow ury or other than the Mental Earth and the result of an utilified at ury or other traumatic event, the Medical Earth at must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10580 ane . Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. De NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ng most of working Elementary/Secondary (0-12) College (1-4or 5+) r's Name (First, Middle, Las To Be Bradbe 19b. Mailing Addr ss (Street and Number or Rural Route 20b. Place of Disposition (Name of MD 21208 Lesville 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Department of Importent: If any injury or once. ^¹ 4 □ Donation 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metas tates Calcenima Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) funeral director, page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Rnown Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2[] No 1 🗌 Yes 2 110 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗀 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Natural 5 Pending 1 Tes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 gerson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Durch 201-109 Lack Neek 31. Date filed (Month AUG

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

1 1 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1, perFH_C846, 8/11/05 TT
State of Maryland / Department of Health and Mental Hygiene = For State Registrar Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Pearry Raymond Bandy Month Day Year **Physician** EARRYY 11-12A M 12 AY 140 3 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, great MEDICAC CENTRAL OF ARE MEDICAC CENTRAL BLOOM (If Under Months)

6. Sex 7. Age (In yrs. last birthday) If Under Months 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HALFORD 362 And Year If Under 24 Hrs. Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Days Director 232-52-8471 July 10, 1934 | West Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10h County 28a-f show traumatic avant, the Medical Examiner rust be notified at 1 ☐ Yes 2 No Abingdon Director Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours atter death with 9 USA items 23a 21009 4028 Sharilynn Drive Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 1 Yes 2 ☐ No 1 Never Married Married ō 1 ☐ Yes 2√∑ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 1954-56 "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Pipe Manufacturer 12 Foreman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of Gertrude Tipton Elias Bandy Annie should Robert ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jes 1 and 2. Jes 1 and 2. Jes the alth an Important: If item 27 is n. any injury or other. 4028 Sharilynn Drive, Abingdon, Maryland Diane Bandy-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Hilltop Services Corp. 8-2-05 Towson, Maryland ice Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCUD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 to 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attanding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 24 1 To the To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2180 2005 101430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YORK NO MuihomiT PRABHO MA 2336 31. Date filed (Month, Day, Year) 32. Registrar's Signature A MARKET AUG 1 1 2005 Registrar

			State	of Maryland / Dep			ental Hygiei	ne	
			For State Registrar	Ce	ertificate of	Death		N2005 26	128
	Physicia /Medic		Decedent's Name (First, Middle, Last) Elva Rose Bachman				2. Date of Death AUGUST	Day 2005 2	J 45 M
	Examin		4a. Facifity Name (If not institution, give street and	number)	4b. City, Town, o	r Location of Death		4c. County of Death	
			Upper Chesapeake Medica	al Center	Bel Ai	r If Under 24 Hrs.	S. Date of Right	Harford	toto or Coreign
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🖾 F	7. Age (In yrs. last birthda 78 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye July 13,	ar) 9. Birthplace (Si Country) 1927 Maryland	
	Maryland	tor	Usuaf Residence of Decedent 10a. State Maryland Harford	10c. City, Town or Bel Air	Location				de City Limits
	th the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Country?	
	ath wi		1410 Bonnett Place		2101			USA	
336	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "netural, or Itams 23e or 28e-f show eumetic event, it a Madical Examiner mat be notified.	by Funeral	1 Never Married 2 Married 1 Tyes,	s 21⊠No	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√2 No	lispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - American India Black, White, etc. Specify: White	an,
Maryland 21215-0036	in 72 hou n "neture Manical E	Completed	15. Decedent's Education (Specify only highest grade complete	ed) (Gi	cedent's Usual Occup ve kind of work done b. DO NOT use retired	durina most of workir	ng 16b	. Kind of Business/Industry	
212	d with giene er tha	Com	12		Beautician			Cosmetology	
D D	oe file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)				(First, Middle, Maid	den Sumame)	
<u>yla</u>	outd I Ment Brke	^c	Lonnie Mack Cheek					ouse	
	d 2 sh th and 7 Is m treum		19a. Informant's Name/Relationship (Type, Print) R. Jean Rowland - S:		Dallam Av			ty or Town, State, Zip Code) Land 21014	
တ်	ges 1 and 2 should t of Health and Men If item 27 Is marke or other treumetic		20a. Method of Disposition		position (Name of rematory or other place			. Location - City or Town, Sta	ite
E S	Pages nent of 1 ent: If its ury or o		1 ⊠Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	JIII State	Mem. Gard		/2005 B	el Air, Maryla	and
altimore,	permit. Pages Department of Importent: If it any Injury or o		21. Sign Jun of Fund of Service I censee		22. Name and Addre	ss of Facility MC	Comas Fu	neral Home, P	.A.
<u> </u>	B I I D		A FILL ONLS	1				n, Maryland 2	
	Priysician		23a. First. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition	at caused the death. Do not en each line.		ng, such as cardiac o	r respiratory arrest,	Onset	ximate al Between and Death HOURS
	/Medical		Due	to (or as a consequence of):		• ,			
	Examiner	- L		TO (or as a some aquines of):	2DIAL INI	FARCTION		28	HOORS
1	ted	nlne	cause. Enter Underlying Cause (Disease or injury	to for de a consequence on.					
4	le be executed ysician and e burial-transit	Examiner	that initiated events c	to (or as a consequence of):		·			
760,	ite be executed iysician and ne burial-transit	cal	d						
Вох 68	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med			3 □Ectopic pregnanc	у		23d. Date of delivery Month Day	Year
o.	the a	yslci	1 \(\text{Vec} 2 \(\overline{\text{DMO}} \)	egnant at time of death nknown	5 Cher (specify)				
۳.	res that the de igned by the be detached	/ Ph	Part II. Other significant conditions contributing I	o death but not resulting in the	underlying cause giv	ven in Part I.	23e. Did tobac	co use contribute to the caus	e of death?
ds,	puires n sign ald be	d by	CANCER LEFT BR	EAST.			1 🗆 Yes	2 No 3 Probably	4 🗀 Unknown
CO	aw requir s been si 2 should l	Completed	DIABETES MELLITO	SS			24a. Was an	24b. Were autopsy find	lings available
æ	The taw cate has page 2:	mo					autopsy performed	? death?	
ta	iclen: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?			26. Pface of Death			
<u>-</u>	Physic this ce al direc	70	1 ☐ Yes 2 ☑ No Hospital: 1	☑Inpatient 2☐ER/Outpat	ient 3 DOA Ott			e 6 ☐Other (Specify)	
n c	ding P. h. After t funera	on:	T LITAGORIA	ate of Injury Month, Day Year) 28b. Time Injur	y Wo	rk?	28d. Describe how i	njury occurred	
Division of Vital Record	or Attend after death Director: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. P	ace of Injury - At home, farm, uilding, etc. (Specify)		Yes 2 □No	28f. Location (Stree City or Town, S	t and Number or Rural Route tate)	Number,
_	Hospitel 4 hours Funerel iely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the dical Examiner: On the and recommendation of the control of th	the best of my knowledge, de te basis of examination and/or manner stated.	eath occurred at the ti	me, date and place, a opinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as stated. and place, and due to the ca	use(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	D.	29c. Licens	_		Date signed (Month, Day, Ye	
			1 tale		D	21207	/	DUGUST 10 YH	2005
	10		30. Name and address of person who completed of FRANZ C. JELLA-CAMI		pe, Print) 5 MIDCRES	T COURT	BALTMORE	, mb 21286	
	Sta	ate	31. Date filed (Month, Day, Year)	Registrar's Signature	land .				

DHMH 17 Rev 1/2001

2145

BACHMAN, ELVA #442274

			State of Maryland / Department of Health an	-	giene	26120
			1 - State Certificate of Death		Reg. Na. 005	20129
	Physicia	an	Decedent's Name (First, Middle, Last)	2. Date of D	eath Day Year	
	/Medic		Carmen Marie Beckwith	08-	06 - 05 4c. County of Dea	10111
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D	Death		
			Franklin Square Hospital Center Hosedale. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Bi	Baltim 9. Bi	tholace (State or Foreign
	Funeral Director			Min. $May 10$	orth Year) 9. Bir ay, Year) 1918 Wis	sconsin
			Usual Residence of Decedent			
	urylan show	b.e	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 💆 No
	death with the Maryland ms 23s or 28a-f show r must be notified at	Director	Maryland Baltimore Chase		10-00	
	with ti		10e. Street and Number 10f. Zip Code 21220		10g. Citizen of What C	ountry?
X	eath	Funeral	310 202 1000	? (Specify Yes or N		erican Indian,
~10	r Iten	Fun	Armed Forces? If Yes, specify Cuban, Mexican, P	uerto Rican, etc.)	Black, Whi	te, etc.
777.6V	within 72 hours atter ane. then "naturel", or Ite	ρ	3 Vidowed 4 □ Divorced If Yes, Give Year or Dates: WW II		Specify: 1	White
5-0	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of	f working	16b. Kind of Business	:/Industry
7	vithin	mpl	Elementary/Secondary (0-12) College (1-4or 5+) Teacher	-	Education	on
200	iled v dygie ther t	ဝိ		Name (First, Middle	e, Maiden Sumame)	<i>,</i> ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
) (land	id be f lental i ked of	To Be	Alex (unk) Stieber Alice		Sonntag	
Seckwith, ℓ	permit. Pages 1 and 2 should be filed within 72 hours atter death with Department of Heatih and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or any injury or other treumatic event, the Medical Examinat must be once.		19a. Informant's Name/Relationship (Type, Print) Michael Beckwith - Son 19b. Mailing Address (Street and Number of S16 Earls Rd., Chase	or Rural Route Numi	ber, City or Town, State, and 21220	Zip Code)
	s 1 and 1 Health tem 27 other t	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City o	r Town, State
Secku	Pages nent of ent: If i	l, i	*4 Donation 5 Other (Specify) Hilltop Service Corp. 8/			
Balt	permit. Departimport Import any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility N 1317 Cokesbury, F			
			23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as car			Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Inary Tract Dechlor resulting in death)			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			inag
	Examiner		Sequentially list conditions, b. End Stage Renal Disease			Lyeurs
10	be sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			11.50.50
` _	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last C. Demen Fac Due to (or as a consequence of):			4 years
092	icate be executed physician and s the burial-transit	calE				
289	ificate g phy as the	_				
ŏ	h cert endin	M/u	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	
Θ.	deatine atte	by Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown		Month	Day Year
P.O.	at the d by the	Phy	9 Unknown	22a Did	tobacco use contribute	to the equipp of death?
Division of Vital Records, P.O. Box	w requires that the death certifica been signed by the attending ph should be detached for use as th	d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease			Probably 4 Unknown
iooa	law rec as beer 2 shou	Completed	Pulmonary Emboli and deep venous thromi	bosis 24a. Wa	posy prior to	autopsy findings available ocompletion of cause of
E.	: The law cate has			per 1 \(\text{Yes}	formed? death? 2 □ No 1 □ Ye	
V. Ita	ysicien: is certitic director,	Be	examiner? Hospital:	f Death (Check only		
of	Phys r this aral di	. To	1 inpatient 2 Envolpatient 3 DOA 4 Nursi	-	sidence 6 Other (Sp how injury occurred	9CITY)
on	iding Ph th. : After th s tuneral	atlor	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
is N	r Atter ter dea irector ir by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or Fown, State)	Rural Route Number,
۵	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely tilled in by the tuneral director, page 2 should be detached for use as the	al Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	place, and due to the	e cause(s) and manner a	as stated.
	the Ho nin 24 h the Fu npietely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated. 29b Signature and title of certifier 29c License number			
	To To	-	29b. Signature and title of certifier 29c. License number D 00.6166	2	08/06/	2005
	121		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	4	00 00	
	W,		Dr. Jonathan Hansen 9000 Franklin Square 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Drive Bo	Himore, M	1.21237
	Sta Regist		29b. Signature and title of certifier 29c. License number D006166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D1. D0 na than Hansen 9000 Franklin Square 31. Date filed (Month, Day, Year) 22. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene TTEM #20bPER FH G846 8711/05 JH Rag. No. 2. Date of Death Month Year **Physician** ranklin arrado 213 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Center Sacrification of the Control Medical of Maryland Chimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10M 2□F 219.01.2204 Yrs. MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director GLEN BURNIE MD ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7975 CRAIN HIGHWAY 201 21061 USA filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status MYes 2 □ No f Yes, Give rear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 'netural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CHAUFFER HOCHSHILD KOHN 7 1H GRADE NIA Pages 1 and 2 should be filed viment of Health and Mental Hygie tant: If item 27 is marked other toury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM CARRADO MADELINE SCHNAPPINGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAUGHTER) BETTE EVANS 858 BRIGHTON PL. GLEN BURNIE MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE CROWNSVILLE, MD 21. Signal re of Funeral Service Licent 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BAUTO NATT PIKE, BALTO MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumania /Medical Due to (or as a consequence of): Examiner monores Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events -0.0 Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? signed by the atte I be detached for 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 12 Yes 3 ☐ Probably 4 ☐ Unknown 2 No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2∏ No 2 No 1 Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. o the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) AUG 1 1 2005

AUG

BOSEL

22 South

32. Registrar's Signature

			For State Registrar	State of N	Maryland		artment of H		Mental Hygie	7000	26131
	Physicia		Decedent's Name (First, Middle	, Last) AUDREY	М.	COPF			2. Date of Death Month	Day Year 0 2005	3. Time of Death 3:41 P M
	/Medic Examin		4a. Facility Name (If not institution,	give street and numbe	r)		4b. City, Town, or	Location of Death		4c. County of Dea	
	Funeral Director		Greater Baltimo 5. Social Security Number 578-32-8669	re Medical 6.Sex 7.4 1□M 2XXF	Center Age (In yrs. las 92	t birthday) Yrs.	TOWSON If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 11-23-19	ar) C	e thplace (State or Foreign ountry) MARYLAND
	ט		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	tor		I/A	Too. Oity,	10411 01 20	BALTIM	10RE			1)(X)Yes 2 □ No
	h the	Irec	10e. Street and Number				10f. Zip Code		10g.	Citizen of What C	ountry?
	ath will	ralD		VENUE		1	212			U.S.	
020	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23a or 28a-f show other traumetic event, the Madical Examinar matter millined at	by Funeral Director	11. Marital Status 1 Never Married 2 Marri Widowed 4 Divorced	12. Was Deceder Armed Forces ed 1 Tyes 2(1) If Yes, Give Year or Dates	s? No		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🂢 💥 o	spanic Origin? (Sin, Mexican, Puerto Specify:	DECITY YES OF NO- DECITY YES OF NO-	14. Race - Am Black, Whi	
ņ	72 ho "netur	eted	15. Decedent (Specify only highes			(Give	dent's Usual Occupa kind of work done d	uring most of wor.	king 16t	. Kind of Business	/Industry
7	within ene. than '	Completed	Elementary/Secondary (0-12) 12 YEARS	College (1-4o	r 5+)	life. l	DO NOT use retired) HOUSEWIFE			OMN HOM	1E
2	ould be filed with Mental Hygiene arked other that stic event, ILE I	BeC	17. Father's Name (First, Middle, I	,					ne (First, Middle, Mai		
7	should b and Ments marked	Tof		MACENROTH		.0		MAF			
Z	and 2 sho saith and n 27 ie m		19a. Informant's Name/Relationsh STEPHANIE A. CO						MORE, MAR		
baltimore,	Pages 1 and 3 ment of Health ant: If item 27 ury or other tre		20a. Method of Disposition 1 Burial Cremation 4 Donation 5 Other (Sp.	3 □Removal from State	te cem	etery, crer	sition (Name of natory or other place SERVICE CO	· NO_1		. Location - City of DWSON , MAF	Town, State
Dall	permit. Pages. Department of It Important: If ite eny injury or of		21. Signature of Funeral Service I		.G.RUTH		Name and Address		. HOME,INC		ORK ROAD ,MD.21204
	Physician /Medical Examiner	-	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Due to force	ed the death. I line. as a consequence of the con	lub nce of): K	er the mode of dying \[\int R \int p	g, such as cardiac	Faulure		Approximate Interval Between Onset and Death
,00,	icate be executed physician and s the burial-transit	I Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseque						
000	licate t	edical		d							
O. DOX	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (FNo 9 □ Unknown		2 Fetal de at time of deal	eath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	s that i ned by e deta	by Ph	Part II. Other significant condition	ns contributing to death	but not resulti	ng in the u	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
cords,	equire sen sig ould b	ted k	GI Hem	mage					1 🗌 Yes	2 □ No 3 □ P	robably 4 Dunknown
วั	e ław r has be je 2 sh	Completed	COAquio	MATTING					24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
VICAL	an: Th ifficate or, pag	a)	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes 2 🔀		s 2 No
	nysicie nis cert direct	To B	examiner? 1 ☐ Yes 2 🕍 No	Hospital:	itient 2 EF	3/Outpatien	t 3 DOA Othe	100	ome 5 Residence	6 □Other (Spe	ecify)
0	ling PI		27. Manner of Death 1 ★Natural 5 □ Pending	9	njury Da <i>y Year)</i>	8b. Time of Injury	Work	at ? ′es 2 ⊡No	28d. Describe how i	njury occurred	
DIVISION	o the Hospitel or Attending Physicien: Althur 24 hours after death. O the Funerel Director: After this certificity completely filled in by the funeral director.	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place of I	Injury - At hometic. (Specify)	e, farm, str	eet, factory, office	es 2 🗆 NO	28f. Location (Stree City or Town, S		ural Route Number,
	ne Hospite n 24 hours ne Funere pletely fille	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical f	g Physician: To the bes Examiner: On the basis and manner	of examination	edge, death n and/or in	n occurred at the tim vestigation, in my op	e, date and place inion, death occu	, and due to the caus rred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within To the comp	Ž	29b. Signature and title of certifier	elSelu	certa	7	29c. License	14728	29d. 8	Date signed (Mon	th, Day, Year)
/	0		30. Name and address of person in the state of the state	who completed cause of	1172	(Type, 65	69 11	· Char	lesStoc	ite Go!	Towsay 40
87	Sta Registr		31. Date filed (Month, Day, Year)	2005 Serve	strar's Signatur	Soc	de				21204
DH	MH 17 Rev 1/20	001	11002								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 0735A M August 2005 COLE HAZEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW MEDILAL CENTER BALTIMORE n/a If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5 Social Security Number **Funeral** Months Davs Hours 1 M 2 F Director 83 Dec. 20, 1921 Maryland 212-18-5321 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County in than "naturel", or Items 23a or 28e-f ehov The Maxical Examiner must be notified at XX Yes 2 No Director n/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2040 Jasmine Rd. 21222 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes **沒**[文]No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white white Specify: Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tin Factory 6th Spinning Bottles Pages 1 and 2 should be filed nent of Health and Mental Hygiant: If item 27 le marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fredia Stailoff Harry C. Scholz ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 I 2040 Jasmine Rd. Baltimore, MAryland 21222 John H. Cole Sr.- son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. = 5 Aug. 6, 05 Baltimore City *4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 22. Name and Address of Facility Loudon PArk Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. BAltimore, MAryland 21229 -23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SISABI Pnysician /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Illustrates Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Cause (Disease or injur) that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕏 No Ö 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 No the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Minpatient 2 ER/Outpatient 3 DOA this 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funeral I 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 RES - 000 August 3,2005 Den Sonting 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Devi Sengupta 4940 Eastern Ave.
31. Date filed (Month, Day, Year) 32. Remstrar's Signature Baltimore, MD 21224 State Registrar

			1 - For Registrar	State of M		Depar		lealth a	nd Mental Hy	•	26133
	Physici /Medio	cal	1. Decedent's Name (First, Midd	Collins			lh Cin Taur		2. Date of De Month		
	Examir Funeral Director	ner	4a. Facility Name (If not institution University of 5. Social Security Number 218, 36, 0389	Maryland Ho	ospita 19 (In yrs. last) 64	birthday)	If Under 1 Year Months Days	If Under 20 Hours	2	NA	rthplace (State or Foreign ountry)
	ס	tor	Usuel Residence of Decedent 10a. State 10b. County	y N/A	10c. City, To	own or Loca				, 25 10 110	10d. Inside City Limits 1 1√2 Yes 2 □ No
	3a or 28a	i Direc	10e. Street and Number 1169 Sargear				10f. Zip Code 212	23		10g. Citizen of What C	ountry?
9036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural, or itema 23a or 28a-1 show other the Medical Evaninar must be notified at	d by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 ☑ Divorced	If Yes Give	'		s Decedent of Hes, specify Cuba	ispanic Origi in, Mexican, Specify:	n? (Specify Yes or No Puerto Rican, etc.)	o- 14. Race - Am Black, Wh Specify: Wh	ite, etc.
Maryland 21215-0036	filed within 72 h Hygiene. other than "natu ent. Ibe Wedien	Completed	(Specify only higher Elementary/Secondary (0-12) 8th	nt's Education est grade completed) College (1-4or	5+)	Sa. Deceder (Give kir life. DO Homem	nt's Usual Occup nd of work done NOT use retired aker	during most (Own Hon	
/land	should be file of Mental Hy marked oth matic even!	To Be	17. Father's Name <i>(First, Middle,</i> Ed)	ward G. Groom	ns _				s Name <i>(First, Middl</i> e 1berta Pau		
	nd 2 sh lith and 27 Is m r traum		19a. Informant's Name/Relations Dolores O'Del				Address <i>(Street :</i> eonard I			рег, City or Town, State, nie, Maryla	
Baltimore,	0 0 - =		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 4 ☐ Donation 5 ☐ Other (3		I		on (Name of tory or other place ematory		Date /9/2005	20c. Location - City o Baltimore,	
Baltin	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licensee Normacuft	1	400	lame and Addres	ss of Facility	Gonce Fur ghway Bal	neral Servi timore, Mar	ce, P.A.
	Priysician /Medical		23a. Part 1. Enter the disease, o shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death)	a. Lung	a consequence	ER	the mode of dyin	g, such as c	ardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
68760,	ate be executed hysician and hysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter Underlying that initiated events resulting in death) Last	C	a consequence						
O. Box	death certific e attending p ed for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant al 9 □ Unknown	2 Fetal dea		ctopic pregnancy hther (specify)			23d. Date of de Month	olivery Day Year
s, P	uires that signed b	by	Part II. Other significant conditi	i ons contributing to death b	out not resulting	g in the unde	erlying cause giv	en in Part I.		tobacco use contribute t Yes 2□No 3□P	o the cause of death?
Il Record	The law requires that the cate has been signed by the page 2 should be detache	Completed							24a. Was auto perfe 1 □ Yes		
f Vital	Phyaician: Th this certificate ral director, pag	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2.XER/	Outpatient	3 DOA Oth	or	of Death (Check only sing Home 5 Res	one) idence 6 Other (Spe	əcify)
Division of	ng fter ne	Certification:	3 Suicide 6 Could	I not be	y Year)	o. Time of Injury	28c. Injury Work M 1 t, factory, office	/at k? Yes 2 □ N	0	how injury occurred (Street and Number or F	lural Route Number
Div	Hospital or Attendii 24 hours after death. Funeral Director: A tely filled in by the fu		4 Homicide	building, et	c. (Specify)			an data and	City or To	wn, State)	
	the the opple	Medical	(Check only 2 Medical one)	Examiner: On the basis o and manner st	f examination	and/or inves	stigation, in my o	pinion, death	occurred at the time,	, date and place, and du	e to the cause(s)
)	Vith COT		29b. Signature and title of certifie	MD			P1358			29d. Date signed (Mon	, way, wear)
	H		30. Name and address of person	MD 2Z	S. Gas	FANE	ST	BALTI	MORE MD	21201	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	Spark	v				

DHMH 17 Rev 1/2001

ORIGINAL

			, For		aryland / Dep				•	
			1 - State Registrar		Ce	ertificate of L			g. N2 0 0 5	26134
	Physici	an	1. Decedent's Name (First, Middle, Las. Marie Dillard	t)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	August	3, 2005 4c. County of Death	7:43 P
			Casey House 6001 I		Mill Rd. e (In yrs. last birthday	Rockville		1855 8. Date of Birth	Montgomer	Ty State or Foreign
	Funeral Director			□ M 2007F	92 Yrs.	Months Days	Hours Min.	(Month, Day, 1	1,1912 UN V	place (State or Foreign ntry)
	show		10a. State 10b. County		10c. City, Town or I				1	10d. Inside City Limits
	he Mai	ector	Md Montgome	ry	Silver S				2:::	1½ Yes 2 No
	3a or 2	Funeral Director	10e. Street and Number 14514 Homecrest Roa	ad Apt. LI	L-4	10f. Zip Code 20906			g. Citizen of What Cour United Stat	
	r deati	nerg	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spec n, Mexican, Puerto R	cify Yes or No- tican, etc.)	14. Race - Americ Black, White,	
036	ours afterell, or l	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔁 I If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Specify:		Specify: Whit	æ
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. do other then "neturel", or Items 23a or 28e-f show event. It e Mudical Exciring must be muilted at	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Giv	edent's Usual Occupa e kind of work done o DO NOT use retired	ation during most of workin)	g 1	6b. Kind of Business/In	dustry
212	filed with Hygiene. Ither ther	Com	Elementary/Secondary (0-12)	College (1-4or 5		issions C]			Univ. of D.	C.
and	should be filed withir or Mental Hygiene. marked other then imatic event, It a Mental in a	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
aryl		To	19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mai		and Number or Rural	Route Number,	City or Town, State, Zip	Code)
	s 1 and 2 of Health a item 27 Is other tree		Pam Tarpley		281	3 Thickett	Way Olne			
nore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify,		Gates of	position (Name of ematory or other place Heaven Ce	em. Aug.		oc. Location - City or To Silver Spri	
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licens	1		22. Name and Addres	ss of FacilityLatn	ey's Fur	neral Home,	Inc.
	405 8 9		23a. Part1. Enjer the disease, or comp shock, of heart failure. List only of	lications that caused					sh., D.C. 2	Approximate Interval Between
E	Priysician		shock, of heart failure. List only of Immediate Cause (Final disease or condition		red Colon (•	. ,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a	a consequence of):					
		ner	if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):					
•	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Cause (Disease of Injury	c. Due to (or as	a consequence of);					
,092	te be e ysician se buris	cai E		d						
89			IF FEMALE:	00- 14						
. Box	The law requires that the death certifica tle has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	Day Year
P.0	that the de ed by the detached		9 ☐ Unknown Part II. Other significant conditions co	9□ Unknown	ut not reculting in the	undarhving on on sive	on in Bort I	23a Did toba	acco use contribute to the	ha course of death?
Records,	w requires to been signer should be c	ed by	Renal Fa		——————————————————————————————————————	underlying cause give	STRIF OILL.			pably 4 Unknown
leco	a law re has bec e 2 sho	Completed						24a. Was an autopsy	prior to con	psy findings available mpletion of cause of
Vital F		e Cor	25. Was case referred to medical	···			00 Bloom of Doorb		No 1 ☐ Yes	2 No
f Vii	dii d	To B	examiner?	Hospital:	ent 2 ☐ ER/Outpatie	ent 3 DOA Othe	26. Place of Death		ice 6 Other (Specifi	iy)
on of	ing After uner		27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b. Time Injury	Work	y at 28 ⟨? Yes 2 □ No	3d. Describe how	v injury occurred	
Division	I or Attending after death. Director: After in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, s c. (Specify)			3f. Location (Stre City or Town,	eet and Number or Rura State)	I Route Number,
۵	To the Hospitel or I within 24 hours after To the Funerel Directompletely filled in b		29a. Certifier 1 Certifying Phy	rsicien: To the best	of my knowledge, dea	th occurred at the tim	ne date and place, ar	nd due to the cau	use(s) and manner as si	tated
	he Hos in 24 h he Fur pletely	edicai	(Check only 2 Medical Exam one)	iner: On the basis of and manner sta	f examination and/or i	nvestigation, in my op	pinion, death occurre	d at the time, dat	e and place, and due to	o the cause(s)
	To the vithin 2 To the complet	Σ	29b. Signature and title of certifie			29c. License	number	290	d. Date signed (Month,	Day, Year)
_	7		30. Name and address of person who c	ompleted cause of d	leath (Item 23a) (Type	, Print)	1278		0/4/0	′フ
2			Charles Harrison	6001 M	luncaster M	Mill rd.	Rockvil	le, Md.	20855	·
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 1	32. Registr	ar's Signature	Snaile				

		1 - For State Registrar	State of Ma	-	ertificate o	Health and I f Death	R	109 NZ 005	26135
Physici		1. Decedent's Name (First, Middle, Last) Helen V.	Dodd				2. Date of Dea August	9, Day 2005 Year	3. Time of Death 11:13 A M
/Medic Examin		4a. Facility Name (<i>If not institution, give</i> s 7850 Marioak Drive			4b. City, Town Elkri	i, or Location of Death .dge	า	4c. County of Dea Howard	
Funeral Director			м 2 хТхF 8	(In yrs. last birthday 33 Yrs.	Months Day		8. Date of Birth Month, Day Dec . 10	9. Bir 5, 1921 Mai	thplace (State or Foreign cuntry) cyland
f show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Howard		10c. City, Town or L Elkridge					10d. Inside City Limits
with the Na or 28a-	Direct	10e. Street and Number)rive		10f. Zip Code	.075	1	log. Citizen of What Co USA	ountry?
be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, It a Medical Examinat must be notified at	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3/XXVidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ So If Yes, Give Year or Dates:	ver in U.S. 13	. Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	te, etc.
filed within 72 hou Hygiene. other than "natural	mpleted t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Dec (Giv lite.	edent's Usual Occ e kind of work doi DO NOT use ret Clerk	cupation ne during most of wor ired)	king	16b. Kind of Business Insurance (,
ould be filed Mental Hygis tarked other tatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Andrew Tawney				18. Mother's Nam		Maiden Sumame) hine Horne	er
nd 2 should by alth and Menta 27 Is marked in traumatic every	-	19a. Informant's Name/Relationship (Type Margaret Possident		19b. Mai 2837	ling Address (Stre Miles A	oet and Number or Ru Avenue Ba	ltimore,	r, City or Town, State, Maryland	zio Code) 21211
permit. Pages 1 and 2 should be Department of Health, and Mental Important: If item 27 Is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R. '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Disp cometery, cri Meadowri	osition (Name of smatory or other p .dge Memo	orial 8/1	Date 2/2005	20c. Location - City or Elkridge, I	
permit. Departmine Importa any inju		21. Signature of Funeral Service License	Henss	/	22. Name and Add Burger—He 5031 Fall	ress of Facility nss—Seitz Ls Road, B	Funeral altimore	Home, Inc	. 21211
Physician		23a. Part1. Enter the disease, or complice shock, or leart failure. List only on Immediate Cause (Final disease or condition		the death. Do not ele.			or respiratory arr	est,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		Pulmonas	Dise	ase	
icate be executed physician and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):					
e death certif the attending ned for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 1 9 Unknown	2 Fetal death 3	□Ectopic pregnal			23d. Date of de Month	livery Day Year
w requires that the been signed by the should be detact	by	Part II. Other significant conditions con	tributing to death bu	it not resulting in the	underlying cause	given in Part I.		bacco use contribute to	o the cause of death?
(0	Completed	Ш					24a. Whas a autops perform	med? prior to death?	utopsy findings available completion of cause of
ing Phy After this uneral d	tion; To Be	27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatier 28a. Date of Injury (Month, Day	y 28b. Time	of 28c. In	Other: 4 Nursing H		e) ence 6 □Other (Spe ow injury occurred	cify)
deat deat ctor: / the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, s . (Specify)			28f. Location (St City or Town	treet and Number or Ri n, State)	ural Route Number,
To the Hospital or A within 24 hours after To the Funeral Direction plately filled in by	Medical C	29a. Certifier 1 ½ Certifying Phys (Check only one) 2 ☐ Medicel Examin	icien: To the best o er: On the basis of and manner stat	examination and/or i	th occurred at the nvestigation, in m	time, date and place y opinion, death occu	, and due to the carred at the time, d	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
Totl withi. Totl	Ň	29b. Signature and title of certifier	flagou		14	onse number	65	9d. Date signed (Mont	10,2005
5		30. Name and address of person who co	Preys 78	eath (Item 23a) (Type 301 Oorsey	Hall Ori	re. Sv.te zo	i, Ellica	H City, MO	21042
Sta Registi		31. Date filed (Month, Day, Year) AUG 1 1 200	32. Egistra	r's Signature	Society !				

		1 - For State of Maryland / Department of H			ene g. N2 () () ()	5 26136
Physic	ian	1. Decedent's Name (First, Middle, Last) CEPHUS DENNISON		2. Date of Death Month August	Day V	3. Time of Death ear 2245 P M
/Medi Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, c Baltim	or Location of Death	and	4c. County of	Death
Funeral Director		5. Social Security Number 6. Sex 180 M 2 F 7. Age (In yrs. last birthday) Yrs. Wonths Days Usual Residence of Decedent		8. Date of Birth (Month, Day, 08 - 24 -	Year) 1918	t. Birthplace (State or Foreign Country) SC
death with the Maryland ms 23a or 28e-f show	5	10a. State 10b. County 10c. City, Town or Location SC N/A GEORGETOWN			-	10d. Inside City Limits 1 1 Yes 2 No
ith the M or 28e-1	Funeral Director	10e. Street and Number 10f. Zip Code		10	g. Citizen of Wh	
sath wil	erai D	2221 JACKSON VILLAGE ROAD 294			USI	•
ia 2 €	y Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married	Rican, etc.)	Black,	American Indian, White, etc.	
5-0036 72 hours after neturel; or Ite	ted by	3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occup	pation	10	6b. Kind of Busin	BLACK ness/Industry
	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) TH GRADE College (1-4or 5+) LONG SHOREM	∌d)		WATERF	DMIT
ind 2 be filed tal Hygi d other	BeCc	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M		ROIGI
aryla should nd Men marke marke	2	LEVY DEUNISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street		ANDROSS al Route Number.	City or Town, Sta	ate, Zip Code)
e, Ma and 2 lealth a m 27 le		OTELIA ALSTON (DAUGHTER) 820 WICKLOW		10. MD 2		
MOre Pages 1 Bent of H Nt: If ite		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 1 ■ Donation 5 □ Other (Specify)	مار. 80		oc. Location - Ci	ty or Town, State
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if tiem 27 is marked other then amportent: if tiem 27 is marked other then appraisant july or other treumetic event, ITEM. 2012.		21. Signature of Funeral Service Licenses 22. Name and Addre VAUGHN C. G		HERAL SER	vice	310, 30
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.	HATT PIKE E	3auo, mo	21229	Approximate
Fnysician		Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION				Interval Between Onset and Death
/Medical Examiner		Due to (or as a consequence of): ACUTE RESPIRATIONY	FAILURE			1 DAY
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
OKUY 8760, ate be executed hysician and the burial-transit		that initiated events ' c				
	Medic	IF FEMALE:		1700		
Bo Beath	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ Unknown	:у		23d. Date of Month	
ords, P.O requires that the een signed by the rould be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given PHZICINSON'S DISENSE	ven in Part I.		acco use contribu	ute to the cause of death?
DENNISON ision of Vital Reco trending Physician: The law re death. ctor: After this certificate has bee	Completed	HYPERTENSION, HYPOTHYROIDISM		24a. Was an autopsy perform	prio dea	re autopsy findings available or to completion of cause of th? Yes 2 No
Vita	Be (25. Was case referred to medical examiner?	26. Place of Death			
n of ng Phy	-	1 Yes 2 No Tospital 1 patient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 4 North, Day Year) 28b. Time of Injury 4 North, Day Year) 28c. Injury 4 North, Day Year)	4 Nursing Ho	me 5 Residen 28d. Describe how		(Specify)
DENNISON Division of Vital Record or Attending Physician: The law requir after death. Director: After this certificate has been si	Certification:	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Yes 2 □No	28f. Location (Stre City or Town,		or Rural Route Number,
DENNISON OF VITAL REC To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral cirector, page 2	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the tire and manner stated.	me, date and place, a opinion, death occurr	and due to the cau ed at the time, dat	ise(s) and mann e and place, and	er as stated. If due to the cause(s)
To t within To ti	M	Marcon	61007	A	rugust	Month, Day, Year) 9 , 2005
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth Knandagle, MD St. Agnes Healthcare	900 Caton	Avenue	Baltimore	, MD 21229
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

			1- State of Maryland / State of Maryland /	Department of Health Certificate of Deal		giene neg. 12005 26137
	Physici		Decedent's Name (First, Middle, Last)	YNSKI	2. Date of Dea Month AUGUST	ath 3. Time of Death
	/Medie Examir		4a. Facility Name (If not institution, give street and number) MARINER CARE OVERLEA	4b. City, Town, or Location BALTIMORE	on of Death	4c. County of Death N/A
	Funeral Director		5. Social Security Number 188-01-9330	rthday) If Under 1 Year If Under 1 Year Months Days Hour	der 24 Hrs. 8. Date of Birti (Month, Day 11/28/	9. Birthplace (State or Foreign (Year) PENNSYLVANIA
	Maryland f show led at	or		on or Location BALTIMORE		10d. Inside City Limits 1 1 X Yes 2 □ No
	or 28e-	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
936	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show then "defel Examiner must be notified at	by Funeral	1631 BELVEDERE AVENUE 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi		USA 14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	filed within 72 hours Hygiene. other then "neturel",	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th GRADE	Decedent's Usual Occupation (Give kind of work done during n life. DO NOT use retired) OWNER		18b. Kind of Business/Industry BAR & RESTAURANT
Maryland 3	be file tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last) WILLIAM DAVIS		other's Name <i>(First, Middl</i> e, ARGARET WILLI	
Mary	d 2 s th ar 7 is treu			o. Mailing Address (Street and Nur. 1800 GONTRUM RO		r, City or Town, State, Zip Code) E, MD 21087
Baltimore,	s 1 a f Hez item othe		20a. Method of Disposition 20b. Place cemet	of Disposition (Name of try, crematory or other place) ROSARY CEMETERY	Date 8/12/2005	20c. Location - City or Town, State DUNDALK, MD
Balt	permit. Page Department of Importent: ff any injury or once.		21. Signature of Funeral Service Licensee	8521 LOCH RAY	VEN BLVD. TOW	•
8760,	/Medical Examiner the printing and printing	dlcal Examiner	234. Vart1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease) a finally that initiated events resulting in death) Last Due to (or as a consequence cause) Due to (or	of):	as cardiac or respiratory an	est, Approximate Interval Between Onset and Daath
O. Box 6	the death certific y the attending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death	a 3□Ectopic pregnancy 5□ Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting MACNUTRITION	in the underlying cause given in Pa		bacco use contribute to the cause of death?
Records,	The law requires that sate has been signed b page 2 should be deta	Completed	UREMIA		24a. Was a autop perfor 1 Yes	sy prior to completion of cause of
Vital	Physicien: this certific al director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/C	Othor	ace of Death (Check only or	
ion of	ter ter	atlon: T		Time of Injury at Work? M 1 Yes 2	28d. Describe h	ow injury occurred
Division	in Direct	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	arm, street, factory, office	28f. Location (S City or Town	treet and Number or Rural Route Number, n, State)
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge and manner stated.	e, death occurred at the time, date nd/or investigation, in my opinion, o	and place, and due to the c death occurred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)
)	To t	M	29b. Signature and title of certifier WHEE M. V	29c. License number 0005	· 0	19d. Date signed (Month, Day, Year) AVGUST 9 2005
	6		30. Name and address of person who completed cause of death (Item 23a NANA CEASAL 821 NO	RTH EUTA	*	
1	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 1 2005	1. fauls		

			Fax	State of	f Marylan	d / Depa	artment of H	lealth a	and Me	ental Hyd	giene)		
		ľ	1 - For Stete Registrar		,	_	rtificate of l				Reg. No	0 0 0	261	38
	Dhusisi		1. Decedent's Name (First, Middle	, Last)						2. Date of Dea			3. Time o	f Death
	Physici /Medic			Zane		ummond				August	9,	2005	5:00	Ам
	Examin	er	4a. Facility Name (If not institution		nber)		4b. City, Town, or	Location of	of Death			County of Dear	th	
	F		422 Haverhill R 5. Social Security Number		7. Age (In yrs. I	last birthday)	Joppa If Under 1 Year	If Under	24 Hrs.	8. Date of Birt		arford	thplace (State	or Foreign
	Funeral Director		410 70 5665	1 X M 2□ F	58	Yrs.	Months Days	Hours	Min.	(Month, Day	y, Year)	1947 Ma	ountry)	ar r araigir
	pu ,		Usual Residence of Decedent		140.00	<u> </u>				MPI II		7517 110		
	laryla shov	j	10a. State 10b. County	-	10c. City	y, Town or Lo	cation						10d. Inside C	2X No
	28a-f	Director	Maryland Harfo	rd	Jop	pa	10f. Zip Code				10a. Cit	izen of What Co	1	
	3a or		422 Haverhill R	5co			21085						,	
	death	Funeral	11. Marital Status	12. Was Dece	ident Ever in U.		Was Decedent of H	ispanic Ori	igin? (Spec	cify Yes or No-		S. A. 14. Race - Ame		
ğ	or the		1 Never Married 2 Marr	ied 1 TYYes If Yes, Giv	2 □No 196	4	1 □ Yes 2√□ No	Specify:		riodri, etc.)		Black, Whit	e, etc.	
5-0036	within 72 hours after death with the Maryland one. Itan "natural", or items 23a or 28a-f show he Medical Examirar must be multibut at	ed by	3 ☐Widowed 4 ☐ Divorced	Year or Da	ates: 1966	6	dent's Usual Occup	ation			105 1		<u>hite</u>	
Ç.	n na	Completed	(Specify only highes		455.	(Give	kind of work done of DO NOT use retired	during mos	t of workin	99	IDD. K	ind of business	industry	
212	giene giene er tha	mo:	12	College (1	-401 5+)		Sale	s			Ind	ustrial	Sales	
Maryland 2121	be filed within 72 hours after death with the Marylan all Hygiene. All Hygiene. And Hygiene.	Be	17. Father's Name (First, Middle,	_						(First, Middle,	Maiden	Sumame)		
<u> </u>	should be filed within nd Mental Hygiene. I marked other than umatic event, It e Mental Hygiene.	욘	Grimes O. Drumm			405 14-10		Maxir			0::	- 0	7. 0	
<u>S</u>	S is as a		19a. Informant's Name/Relations Sue Drummond (W				ng Address <i>(Street .</i>							
	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition		20b. P	lace of Dispo	averhill sition (Name of matory or other place		Da	ate		nd 2108 ocation - City or		
altimore,	Pages nent of int: If it iry or o		1 ⊠Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (S		State		Valley Me	1 '	8/11/ ard		Ti m	onium,	Marvlar	nd
alti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	dicensee	0	F 23	Name and Address	ss of Facilit	tv			OHILLIN,	rkiry ran	i.u
<u> </u>	90 E E 9		youn W. F	sur roust	E		407 OLG E	aster	m Av	enue E	sse	x, Mary		
			23a. Par 1. Enter the disease, or shock, or heart failure. List	only one cause on e	ach line.				,	respiratory ar	rest,		Approxima Interval Bel Onset and	tween
ĺ	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	bronove	AIN	cry PIS	eose	!					
	Examiner			Due to (or as a consequ	uence of):	,							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	uenca of):								
	ocuted nd transil	Examiner	that initiated events	c									l'i	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	E E	resulting in death) Last	Due to (or as a consequ	uence of):								
687	physics the t	dical		d										
Box	eath certific attending p	√Me	IF FEMALE: 23b. Was decedent pregnant		come of pregna							23d. Date of de	livery	
W	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		irth 2 ☐ Fetal ant at time of de		<pre>Ectopic pregnancy Other (specify)</pre>					Month	Day	Year
P.O.	at the	Phys	9 Unknown							1				
Š,	w requires that the de been signed by the should be detached	by	Part II. Other significant condition	Ober 17	eath but not resu	ulting in the u	nderlying cause givi	en in Part I.	*		obacco i /es 2	use contribute to ⊠No 3 ⊡ Pr	othe cause of cobably 4 🖂	
Š	r requ	etec	Diahet	s Nelli	4-1-					24a. Was				
Rec	he lav e has	Completed	12/14/1800	D MILIT	100					autop perfo	sy rmed?	prior to death?	utopsy findings completion of c	available cause of
ta	i ician : The lav certificate has rector, page 2	Be C	25. Was case referred to medical					26. Place	of Death	(Check only o	2[XNo	1 □ Yes	2 No	
>	nysici nis cen direc	To B	examiner? 1 ☐ Yes 2 ☐XNo	Hospitai: 1 □ I	npatient 2	ER/Outpatie	nt 3 DOA Oth			****		6 □Other (Spe	cify)	
Division of Vital Records,	Attending Physician: or death. ector: After this certification in the funeral director.		27. Manner of Death 1 Xatural 5 ☐ Pendin	9	of Injury th, Day Year)	28b. Time o Injury	Worl	_		8d. Describe h	now inju	ry occurred		
Sio	ttend death stor: /	icat	2 Accident investig	not be	of Injuny - At ho	me farm et	M 1 □	Yes 2□	-	Rf Location /9	Street ar	nd Number or Ri	ural Poute Num	nhor
<u>></u>	after Direction by	Certification;	4 ☐ Homicide determ	ined 200. Flace	ng, etc. (Specify	/)	eet, ractory, onice			City or Tou			Irai noute ivuri	iber,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page			g Physician: To the								and manner as	stated.	,
	To the He within 24 To the Fu	edical	(Check only 2 Medical one)	Exeminer: On the ba and man	asis of examination and the stated.	tion and/or in	vestigation, in my o	pinion, dea	ith occurre	d at the time,	date and	d place, and due	to the cause(s)
1	Vith To 1	Σ	29b. Signature and title of certifie				29c. Licens	e number	0	:	29d. Da	te signed (Mont	h, Day, Year)	
	+1-		> S Muun	MVI		00-1-0-	1)10	248			1	7/5)		
jt	77		30. Name and address of person Chaldon Milner	4.	e of death (Item	1 23a) (Type,	Print)	Re	(21	7371				
	Sta	te	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ture	de la							
	Registi		AUG 1	1 2005	Hereco.	JE A	peace							

		For State of Maryla	nd / Depa	artment of Heal	lth and Men	tal Hygier	2005	26139
Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Evelyn T. Engle 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	Atlation of Death		2005 4c. County of Deal	3. Time of Death 8:03 a N
Funeral Director		220-20-0159 1□M 2 Ŭ F 77	s. last birthday) Yrs.			Date of Birth	altimore 128 Mar	hplace (State or Foreig "Y"Yand
If I I I I I I I I I I I I I I I I I I	ector	Md. Baltimore	Cockey	sville				10d. Inside City Limit 1 ☐ Yes 2 🐴 N
death with I	Funeral Director	10e. Street and Number 10535 York Rd. #315 11. Marital Status 12. Was Decedent Ever in	U.S. 13.	10f. Zip Code 2103 Was Decedent of Hispan f Yes, specify Cuban, Me			Citizen of What Co	USA ncan Indian,
77 hours after death with the Marylar 7 natural; or teme 23a or 28a-f ehow policial Evar in artmant to notified at	by	Armed Forces? 1 Never Married 2 Married I Yes, Give Year or Dates: Armed Forces? 1 Yes, Give Year or Dates:	16a Dece	1 ☐ Yes 2 💆 No Sp	ecify:		Specify: WY Kind of Business/	ni te
nd 2 should be filed within 72 hours aft this and Mental Hygiens 27 is marked other than "natural; or r traumatic event, the Medical Event	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)	(Give	kind of work done during DO NOT use retired) Secretary			Law	
e d la la	To Be	Joseph Grill 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir		Mother's Name (Fir Mary Ian Jumber or Rural Ro	eo		(ip Code)
S 1 a of Hee		X	Place of Dispo	lampston Gar sition (Name of natory or other place) Service Co.	th Luthe Date 8-12-0	20c.	Md. 2109 Location - City or DWSON, Mc	Town, State
permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Pervice Licensee	22	Ruck and Address of 1 1050 York R	Familyneral d. Towson	Home, I	nc 1204	
death certificate be executed EXA Wedical Be attending physicien and dor use as the burial-transit	icai Examiner	23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consection of the cause (Disease) or injury that initiated events resulting in death) Last Due to (or as a consection of the cause (Disease) or injury that initiated events resulting in death) Last	quence of):	FNFARCT		piratory arrest,		Approximate Interval Between Onset and Death
death certif e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant at time of 9 Unknown 4 Pregnant at time of 9 Unknown	tal death 3□	Ectopic pregn <i>a</i> ncy Other (s <i>pecify)</i>		11.	23d. Date of deli Month	very D <i>a</i> y Year
law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not re	sulting in the ur	nderlying cause given in I	Part I.	23e. Did tobacco		the cause of death?
The ate ha	Completed					24a. Was an autopsy performed? I Ves 2	prior to death?	topsy findings available omptetion of cause of 2□ No
ding Phye n. After this funeral di	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Hospital: 1 Inpatient 2 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	ER/Outpatien 28b. Time of Injury					rify)
nital or Attending us after death. ral Director: Afte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec	ify)			City or Town, Sta	- 5115	·
To the Hospital or Attend within 24 hours after death To the Funeral Director. completely filled in by the	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated. 29b. Signature and title of certifier	owledge, death ation and/or inv	29c. License num	, death occurred at	the time, date a	nd place, and due Pate signed (Month	to the cause(s)
1		30. Name and address of person who completed cause of death (Ite Mark Saba, MD	m 23a) (Type, Scott	00058 Adam Rd. #2			3/08/2 Md. 210	
Sta Registr		Mark Saba, MD 31. Date filed (Month, Day, Year) AUG 1 1 2005						

			For State Registrar	State of I	Marylar		artment o			1ental Hy	giene	105	26110
	0		Decedent's Name (First, Middle	e, Last)						2. Date of De		100	3. Time of Death
F	hysici		Anna Marie	Eder						Month August	5, 20	Year	
	/Medic Examin		4a. Facility Name (If not institution		9r)		4b. City, Tow	m, or Locat	tion of Death	nugust		unty of Dea	
			Upper Chesape	ake Medical	. Cent	er	Be	l Air	-		На	rford	1
Fı	uneral		5. Social Security Number	6. Sex 7.		last birthday)	If Under 1 Y	ear If Un	nder 24 Hrs.	8. Date of Bi	rth	9. Bi	rthplace (State or Foreign
Di	rector		213-50-6933	1 □ M 2 🔀 F	94	Yrs.	MOTITIES DE	ays Hou	IIS MIN.	(Month, Da Feb. 2			rvland
Pu	3		Usual Residence of Decedent 10a. State 10b. County		100 Cit	y, Town or Lo	aatiaa						
faryle	sho le pa	JQ.	_										10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the N	28e-i	Director	Maryland Har: 10e. Street and Number	ford		Forest	Hill 10f, Zip Coo	4.			10- 00		
with	Sa or		1 Colgate Dri	ve Room 71	5		Tor. Zip Coo	210	150		10g. Citizen	or what C SA	ountry?
Jeath	ns 23	Funeral	11. Marital Status	12. Was Decede		.S. 13 V	Vas Decedent			acify Yes or No			erican Indian,
ter o	r Itar	표	1 Never Married 2 Marr	Armed Force	s?	1	Yes, specify (Cuban, Mex	kican, Puerto	ecify Yes or No Rican, etc.)	, , , ,	Black, Wh	
Og s	el', o	þ	3 Widowed 4 ☐ Divorced	II Yes, Give Year or Date	s:		I□Yes 2🔯	No Spe	cify:		Spe	ecify: W	hite
:1215-0036 within 72 hours after death with the Maryland ena.	lical	Completed	15. Decedent (Specify only highes			16a. Deced	lent's Usual Oc	cupation	most of work	ing.	16b. Kind o	f Business	/Industry
F E 5	" Mer	nple	Elementary/Secondary (0-12)	College (1-4d	or 5+)		kind of work do OO NOT use re		INDS! DI WOIK	iiig			
ed v	tt. th		7			Hor	nemaker				1	n Hom	e
ba fi	ever	Be	17. Father's Name (First, Middle,					18. M	-	First, Middle			
Nould Mer	narke	ဥ	George (u/k)	Wolf					Anna	(u/k)	Seit		
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental Hygiena.	7 is r treur		19a. Informant's Name/Relations! Michael D. Ede:							Al Route Numb		wn, State,	Zip Code)
e 1 an Heal	em 2		20a. Method of Disposition	r – 2011	20b. P	-	sition (Name o			ir, MD		on - City or	Town, State
ages of of	t: If it	and com-	1 🕅 Burial 2 ☐ Cremation		te C	emetery, cren	natory or other	place)				•	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena.	injun	- 1	' 4 □ Donation 5 □ Other (S) 21. Signatur of Funderal Service		Oal		Cemete Name and Ad		8-8-0				Maryland
B ag	any ir		Maries a.	Enge /					110				e, P.A. and 21009
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the deat							чатут	Approximate
Promo	sician		Immediate Cause (Final	-1									Interval Between Opset and Death
	edical		disease or condition resulting in death)		as a consequ	(u/ur	010	20161	n				Lhours
Exa	miner												
	-	Je.	Sequentially list conditions, if any, leading to immediate cause. E. C. J. Cause (Disease or injury	Due to (or a	as a consequ	uence of):							
₹ § .	ransi	Examiner	that initiated events	с									
	ian a		resulting in death) Last	Due to (or a	as a consequ	uence of):							
8760, Cate be executed	physician and s the burial-transit	dical		d									
	ding p	Mec	IF FEMALE:										
. Box 6	attending p	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fetal	death 3	Ectopic pregna	incy				Date of de Month	livery Day Year
. 0	by the	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	4□Pregnant 9□Unknown		eatn 5∟	Other (specify						-4,
·	ignad by	by Physiclan/Me	Part II. Dther significant condition	ns contributing to death	but not resu	ulting in the un	deriving cause	given in Pa	art I.	23e. Did to	obacco use c	ontribute to	the cause of death?
Records,	ld be									10	-1		obably 4 Unknown
O E	should t	lete								24a. Was	20 24	h Mora o	
7	e has	Completed								autor		prior to death?	utopsy findings available completion of cause of
	certificate h		25. Was case referred to medical					00.0		1 ☐ Yes	2 No	1 🗌 Yes	2 □ No
	direct	0	examiner?	Hospital:	tient 2	ER/Outpatient	3□ DOA	0.4		(Check only only only only only only only only		Dah (C	-16.1
o a y a d	드 교	n i	27. Manner of Death	28a. Date of Ir	ijury	28b. Time of	28c. li	njury at		28d. Describe I			ciry)
Attendin death.	r: Aft	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investig		Day rear)	Injury		Work? □Yes 2	! □ No				
UIVISION I or Attending after death.	rector: After by the funera	tific	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of I	njury - At ho etc. (Specify	me, farm, stre	et, factory, offi	ce	2	281. Location (S City or Tov	Street and Nu	mber or Ri	ural Route Number,
Ts aft	ad in	Certification:		oundarie,	-					Oily of 10V	vii, State)		
DIVISION To the Hospital or Attending within 24 hours after death.	To the Funerel Discompletely fillad in		(Onser Sin) Z Niedical E	g Physician: To the bes	oi examinat	wledge, death	occurred at the	e time, date	and place, a	and due to the	cause(s) and	manner as	stated.
the hin 2	The The	Medical	0,107	and manner	stated.								
To	000		29b. Signature and title of certifier	MA			29c. Lice	ense numb	er 7		29d. Date sig	ned (Mont	n, Day, Year)
		-	1/1/	6.17)			-	- 76	,	/	rugust	1,	2003
	10		30. Name and address of person v	who completed cause of	Confliction	23a) (Type, F	rint)	Bil	Ain	Man	1/11	1	21014
	Stat	6	31. Date liled (Month, Day, Year)	⊿2. Regis	trar's Signat	ture	, '			/	1199	/	010/
*	Registra		AUG 1 1 20		, H.	A DOLL	2						

				State of Maryland / Dep.	artment of Health and	Mental Hygiei	ne					
			For Stete Registrer	-	rtificate of Death	Reg.	2005 2011.1					
8	- A - 1		Hegistrer Decedent's Name (First, Middle, Last		- Death	2. Date of Death	3. Time of Death					
	Physici		Donnie 1	lee Foster =	10.	August						
	/Medic		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea		4c. County of Death					
	Examin	er	2410 Winchester S		Baltimore							
, gaz-	Funeral	-	5. Social Security Number 6. Se		If Under 1 Year If Under 24 Hrs		ar) 9. Birthplace (State or Foreign Country)					
9	Director			M 2□F 26 Yrs.	Months Days Hours Min	. Month, Day, Ye	1979 maniland					
	D		Usual Residence of Decedent				Trunguna					
	show	_	10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits					
	Ba-f s	ct Ct	mg.	TH D	alamore		1 Yes 2□No					
	ith th	Dire	10e. Street and Number	1 + St.	10f. Zip Code	10g.	Citizen of What Country?					
	ath v	by Funeral Director	2404 WINC	heser	21216		USA					
	er de Item	une	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc./					
36	rs aft	Ϋ́F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black					
5-0036	within 72 hours after death with the Maryland ane then 'neturel', or iteme 23a or 28a-f show he Nadleal Examinar must be notified at		15. Decedent's Edu		ident's Usual Occupation	166	. Kind of Business/Industry					
215	n "n	Completed	(Specify only highest grad	de completed) (Give	kind of work done during most of wo DO NOT use retired)	orking	Kipken					
212	iene r the	E O	Elementary/Secoridary (0-12)	College (1-4or 5+)	Student	L	Learning Center					
	a filed Il Hygiv other	Bec	17. Father's Name (First, Middle, Last)	- + C-	18. Mother's Na	me (First, Middle, Maid						
<u>la</u> r	ould be Mental arked o	To B	Donnie le	roster SR,	Lina	a Joh	in Son					
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene teams 23a or 28a-f show then 27 ie marked other then "neture!", or iteme 23a or 28a-f show other traumatic event, the Medical Exercitar must be notified at		19a. Informant's Name/Relationship (T)	ype, Print) 19b. Maili	ing Address (Street and Number or R	_						
-	and 2 lealth m 27 i		Lisa toste		2 fembridge	Ave. Bo	eto, md, 21215					
Baltimore	of He of He roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	- 1	. Location - City or Town, State					
Ĕ	Page nent o ant: If ury or		4 Donation 5 Other (Specify)		on Cem Hug	,17,200 L	ansdowne, md.					
alt	permit. Page Department o Important: If eny injury or once.		21. Signature of Funeral Service Licens	300	2. Name and Address of Facility	Whi St.	Batto, md, 21229					
<u> </u>	82 5 8		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Running St. Bacto, md, 212 1950 W. Frankler St. Bacto, md, 212 1965 W. Frankler St. Bacto, md, 212 1965 W. Frankler Funeral Service									
			23a. Part . Eriter the disease, or comp shock, or heart failure. List only o	lications that caused the death. Do not en one cause on each line.	ter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between					
Pin.	Physician		Immediate Cause (Final disease or condition	M. Hil. Gara	1 t 1) = 1		Onset and Death					
-	/Medical		resulting in death)	Due to (or as a consequence of):	(a) (b) 0-00-4015							
÷.	Examiner		Sequentially list conditions.	b								
9	sit sit	Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):								
1	and and -trans	Cam	that initiated events resulting in death) Last	C. Pun to (or on a concession of):								
60,	s be executed sician and burial-transit			Due to (or as a consequence of):								
8760	eath certificate be exattending physician for use as the buria	dicai		d								
9 X	ding ding se as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnancy								
Вох	atten for u	ian	in the past 12 months?	1 Live birth 2 Fetal death 3 €	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year					
Ö	that the dead by the detached	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown								
P.0	res that the igned by be detact		Part II. Dther significant conditions co	ontributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?					
S	sign d be	l by				1 ☐ Yes	2 No 3 Probably 4 Unknown					
O		9					/ 1					
cord	w requir	letec					24h Wara autoney findings available					
Record	he faw requ s has been ge 2 shoul	mpletec				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?					
tal Record	The far ate has page 2	Completed	25. Was case referred to medical			24a. Was an autopsy performed	prior to completion of cause of death?					
Vital Record		Be	25. Was case referred to medical examiner?	Hospital:	Other	24a. Was an autopsy performed 1 Yes 2 ath (Check only one)	prior to completion of cause of death? No 1 A Yes 2 □ No					
of Vital	Physician: this certifica al director, s	To Be	examiner?	28a Date of Injury 28b Time o	nt 3□ DOA Other: 4□ Nursing I	24a. Was an autopsy performed 1 X Yes 2 ath (Check only one)	prior to completion of cause of death? No 1					
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of Vital	Physician: this certifica al director, s	To Be	examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury - At home, farm, sti	nt 3 DOA Other: 4 Nursing of 28c. Injury at Work? 1 Yes 2 No	24a. Was an autopsy performed Yes 2 ath (Check only one) ath (Check only one) The series how in the series of th	prior to completion of cause of death? No 1					
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			1 - For State Registrar	State of Marylan		artment of F			giene	2611.3
			Hegistrar Decedent's Name (First, Middle, Last)			timodio or	2000	2. Date of Dea		3. Time of Death
	Physici		William Frey	Sc				Month 8	Day Year	14:30 M
	/Medic		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death		4c. County of Dea	
	Examin	er	Johns Hofkins Bay		Her	Baltimo		1 -1	n/a	
	Funeral		5. Social Security Number 6. Sex			If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9 Bir	thplace (State or Foreign ountry)
	Funeral Director			M 2□F 81	Yrs.	Months Days	Hours Min.	Month, Day	y, Year) C 1923 N	Maryland
			Usual Residence of Decedent			1		500. 17	, , , , , , , , , , , , , , , , , , , ,	, <u></u>
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Mar Fed st	tor	Maryland n/a		Baltim	ore				1 X Yes 2 ☐ No
	h the	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	1) wit	by Funeral Director	6010 Eastern Parkı	uay		21 206	5		USA	
	deat	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No	- 14. Race - Am Black, Whi	
ထွ	after or Ite	Ē	1 ☐ Never Married 2 🔀 Married	1 X Yes 2 □ No WW If Yes, Give	TT	1 ☐ Yes 2 🔀 No		,		hite
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show the Medical Examinar must be notified at	d b	3 Widowed 4 Divorced	Year or Dates:						
5	72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	dent's Usual Occup kind of work done	during most of work	king	16b. Kind of Business	s/Industry
7	han '	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	ia)		State of	
	led w lygiei her ti	S	47 Fabrus Norw (First Middle Local)	J	Engi	neer	19 Mothods Nam	o (First Middle	Mary Maiden Sumame)	Tano
ng	be fi	Be	17. Father's Name (First, Middle, Last) Harvey Winfield Fi	nav				Kettern		
3	Mer Market Matic	٦°			405 M-10	- 4 4 4 / (Channel				Zin Codo)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Madical Examinat must be notified at an once.		19a. Informant's Name/Relationship (Ty	•					er, City or Town, State,	
	1 and Healt em 2 ther		Mildred L. Frey/t			cas term	rarkway,	Date	ore, Maryla 20c. Location - City o	
Ö	ges it of h		1 ☐ Burial 2 ☑ Cremation 3 ☐ P		cemetery, crei	matory or other pla	nce)	0/2005	Towson, M	
tim	t. Pa tmer tant: ijury		`4 □Donation / □Other (Specify)		•	•	1 2			Home, Inc.
Baltimore,	Depar Depar Impor any Ir		21. Signature of Fine al Service Licensi	96						
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			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ne cause on each line.	n. Do not en	ter the mode of dyl	ng, such as cardiac	or respiratory ar	rrest,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	CAD						
	/Medical Examiner		resulting in death)	Due to (or as a consec	uence of):					
Н	LAGIIIII	5	Sequentially list conditions, if any, leading to immediate	Due to (22 22 2 22 22 2						
	pe jis	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	tuence or):					
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8760,	ate be executed hysician and the burial-transit			230 (0 (0. 00 0 00.000	(461.05 5.7.					
87	physi physi the b	dical		d						
39 x	death certifics e attending ph id for use as tl	Me	IF FEMALE:	3c. If yes, outcome of pregn	ancy				22d Date of de	livon
Вох	ath cather	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta	al death 3	☐Ectopic pregnand ☐ Other (specify)	Ey		23d. Date of de Month	Day Year
0	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of o 9 Unknown	ieath 5L	_ Otner (specify) _				
٥.	that the de led by the a detached f	P.	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	inderlying cause gr	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ds,	ires tha signed d be det	1 by	COPP, CHF	ESAN	_	, , ,		10	Yes 2□No 3□F	robably 4 Nhknown
Records	law requires as been sign 2 should be	Completed	(0)	,				240 1860	an I 34h Wasa s	utocov findings available
€C	elaw hasl	ld L						24a. Was autop	prior to death?	tutopsy findings available completion of cause of
	Thate page	S						1 ☐ Yes	2XNo 1 □ Ye	
of Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0:	her	ith (Check only o		-
of	Phys this al dii	J.	1 ☐ Yes 2 No	1 Inpatient 2L	ER/Outpatie	nt 3 DOA	4 🗆 Nuising n		dence 6 Other (Sp how injury occurred	ecify)
L	ling After fune	lo l	1 Natura! 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wo	ork?]Yes 2 □No	200. 2000.120		
Sic	ten leat tor: the	Cal	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm st			28f. Location (Street and Number or F	Rural Route Number.
Division	3 5 7 6	Certification;	4 Homicide determined	building, etc. (Speci	fy)	root, tablery, smoo		City or Tox		
	Hospital 14 hours a Funeral I		29a. Certifier 1 Certifying Phy	sician: To the best of my kn	owledge, deal	th occurred at the t	me, date and place	, and due to the	cause(s) and manner a	as stated.
	24 h 24 h Fur	edical		ner: On the basis of examination and manner stated.						
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mor	nth, Day, Year)
	F > F 0		1	> M.D		* * * * * * * * * * * * * * * * * * *	60628	′	8/8/05	
,	In The		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type	Print)	,-0-0		1 - 1	
	1041		Esther Oh M.D.	5505 Hapk	ns Ba	yview Ca	Bal-	timore.	MD 2/22	4
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature		,		/	
	Regist		AUG 1 1 2005	Here is	400	de			MD 2122	

				artment of Health and Mertificate of Death	ental Hygien	2000 0000
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici: /Medic		Walter Fred Fuller		August 4,	2005 7:30 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
			1542 Deerfield Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Darlington If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Harford
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 4. Yrs. 2 F 93	Months Days Hours Min.	(Month, Day, Year	9. Birthplace (State or Foreign Country) 1912 Virginia
	D		Usual Residence of Decedent		710111 23,	
	arylar show	_	10a. State 10b. County 10c. City, Town or to			10d. Inside City Limits 1 ☐ Yes 2X No
	the Mi	ecto	Maryland Harford Darling	ton 10f. Zip Code	10a C	itizen of What Country?
	with 3a or	直	1542 Deerfield Road	21034	USA	
	death ms 23	Funeral Director	11 Marital Status 12 Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28e-f show any Injury or other traumatic evant, The Medical Examples Injurited at angle.	y Fui	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☒ No Specify:	ritoari, oto.)	Sansitu.
21215-0036	hours tural',	d by	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation	16h	White Kind of Business/Industry
7	in 72 n "na	piete	(Specify only highest grade completed) (Given life.	e kind of work done during most of worki DO NOT use retired)	ng	and or baomooding
212	d with giene ar tha	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 Fam	ner	Dai	iry/ Agriculture
p	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	_	(First, Middle, Maide	
Maryland	d Men d Men narke	P P	James Clayton Fuller	HazeL		larmon
Ma	d2sh thand t7 Isin traun			2 Deerfield Road, D		
	Heal Hem 2		20a. Method of Disposition 20b. Place of Disposition			Location - City or Town, State
SE SE	Pages ent of nt: If I		1 ⊠Burial 2 □ Cremation 3 □ Removal from State	Mem. Gardens 8/08/	05 Abe	erdeen, Maryland
Baltimore,	permit. Departm Importa any Inju					eral Home, P.A.
<u> </u>	82529		Marles (1. Singe)	1317 Cokesbury Roa		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one caused neach line.	nter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	OF THE PANK	KEAS	6 MONTHS
	Examiner		Due to (or as a consequence of):			
L		Jer	Sequentially list conditions, if any, leading to immediate once the lader by income of the			
W	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c			
8760,4	cate be executed obysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical	d			
Box 6	leath certifice attending ph I for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
	that the death cer ed by the attendir detached for use	icia	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.O.	at the I by th stache	hys	9 Unknown		CO. Distance	and the second death?
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Onknown
Ö	requi	Completed			24a. Was an	
Rec	9 4 9	ldm			autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Records,		e Co	25. Was case referred to medical	26 Place of Deatl	1 Yes 2 N	o 1 Yes 2 No
	Physician: this certific ral director,	To B	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpat	Other		6 ☐Other (Specify)
n of	ding Ph n. After th funeral		27. Manne of Death 1 Avatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how inj	ury occurred
Sio	Attending it death.	cati	2 Accident investigation	M 1 Yes 2 No	29f Location /Street a	and Number or Rural Route Number,
Division	or At after of Direct in by	Certification;	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could flot De determined building, etc. (Specify)	street, factory, office	City or Town, Sta	
_	spitel		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de			
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	(Check only one) 2 Medical Exeminer: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr		
	To the comp	Σ	29b. Signature and title of certifies	29c. License number	-11 29d. D	ate signed (Month, Day, Year)
•			Could X worslein MD	V00 L115	7 8	17/06
	.)		30. Name and address of person who completed cause of death (Item 23a) (Typ KOUIS SILUER STEIN 80E	SOUTH UNION!	AVENUE H	AVE DE GRACE, MI)
	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 1 2000	de la		·

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. N2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:15 P M 2005 August 09 I. Margaret Grohe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner Baltimore Towson Gilchrist Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🔀 F New Jersev Yrs. June 07 1926 149-14-3971 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No by Funeral Director Md. Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204 USA 8207 Rider Ave. 23a 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2√2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental Department of Health and Menta important: if Itam 27 is marked eny injury or other treumatic evonce. Irene Margaret Higgins John Martin Perrin Pages 1 and 2 should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8207 Rider Ave. Towson, Md. 21204 Mr. Joseph Grohe, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hillton Service Co. 8-15-05 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rohns **Physician** ans /Medical Due to (or as a consequence of): Examiner weeks cute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 TUnknowh 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Srillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this After this funeral of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: To the Hospitei or Attending s after dea... rai Director: Afr 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of contrier · mo person who completed cause of death (IJem 23a) (Type, Print) N. Charles J. Rolfo. Md 2120/ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1- State of Mary	•	artment of F		Re	g. N 2. []	05 26146
	Physici	an	Decedent's Name (First, Middle, Last) TOWNS A THEOLOGY AND TOWNS A THEOLOGY				2. Date of Death	Day	Year 3. Time of Death
	/Medid Examin		EDWARD A. HENDRICKSON JR. 4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	Location of Deat	AUGUST	4c. Count	005 2:30 P M
			364 DREW ST		BALTIMO				
	Funeral Director		5. Social Security Number 214.30.6747 Usual Residence of Decedent 6. Sex XX 7. Age (In 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 1935	9. Birthplace (State or Foreign Country) MD
	yland			. City, Town or Lo	cation				10d. Inside City Limits
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	death ms 23	nera	364 DREW ST 11. Marital Status 12. Was Decedent Ever	in U.S. 13. V	21224 Vas Decedent of H Yes, specify Cuba		pecify Yes or No-		USA ce - American Indian,
9	or Ite		1 ☐ Never Married XX Married XYYes 2 ☐ No If Yes, Give	,	Yes, specify Cuba		o Rican, etc.)	Specia	ck, White, etc.
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ary E	2 should and Men is marke aumatic	ဥ	EDWARD A. HENDRICKSON, SR 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street		D FRANCES ural Route Number,		
Σ,	1 and 2 : Health ar tem 27 is		DOROTHY HENDRICKSON WIFE				RE, MD 21		,,
Baltimore,	0 0 = 5	- 33	20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State	b. Place of Dispos cemetery, cram	sition (Name of natory or other place	(8)	Date 2	Oc. Location	- City or Town, State
Itim	Pa men ant: ury	1	`4 ☐ Donation 5 ☐ Other (Specify)		N CEMETE			LEN BU	RNIE, MD
Ba	permit. Departr Imports any inj		21. Signatur (Ameral Service Licensee) K. GREGURY FUNK MO1148		NK FUNERA			2 MD 1	21061
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9	artifica ling ph e as th		IF FEMALE:						
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	Hospite 4 hours Funeral ely fille	edical	29a. Certifier (Check only one) XX ertifying Physician: To the best of my one 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, death ination and/or inv	occurred at the timestigation, in my op	e, date and place pinion, death occu	, and due to the cau rred at the time, dat	ise(s) and ma e and place,	nner as stated. and due to the cause(s)
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	10		30, Name and address of person who completed cause of death (R.A- CA	Print) AND	57870	MD 212	24.	
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 State Registramend ITEM #5 PER FII C846 8/11/05 JII Date of Death Month **Physician** SARAH ELIZABETH HANDY /Medical 4c. County of Death 4b. City, Town, or Location of Death Eacility Name (If not institution), give street and nymber **Examiner** NA land 1 Year If Under 24 Hrs. 8 Date of Birth Month, Day, Year 12 - 13 - 193 Birthplace (State or Foreign Country)
 MD 7. Age (Ih yrs. last birthday) 5. Social Security Number 11.NK 6. Sex **Funeral** Months 1 □ M 2 🗷 F Director 217-24-217-24-2381 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 is marked other than "natural", or itams 23s or 28a-f show other traumatic avant, the Medical Evanting that the mutified at 1 KYes 2 No Director NIA BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number AVENUE 21229 4 SOUTH ABINGTON USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If itam 27 is marked other than "natural", or Itam any injury or other traumatte avant, the Madical Examina ☐Yes 2 Yes, Give 2 No 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) DOMESTIC NA HOME MAKER 11 TH GRADE 17. Father's Name (First, Middle, Last) LINK 18. Mother's Name (First, Middle, Maiden Sumame) Be AGNES FLEET 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4 SOUTH ABINGTON AVE., BALTO MO 21229 (HUSBAND) JOHN E. HANDY SR Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-13-05 MD. NATH CEMETERY LAUREL, MO 21. Signature of Funeral Service Licen 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO, NATO PIKE, BALTO, MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death to Small Bowel Immediate Cause (Final disease or condition resulting in death) hock secondary **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical as the b IF FEMALE: 950 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ò in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) the page 2 should be detached 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes 2 1 No filled in by the funeral director, Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 No 2 1 Tes 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of a Hospital or Attending Pl 24 hours after death. e Funaral Diractor: After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funaral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number o completed cause of death (Item 23a) (Type, Print) 10 and

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day

Year)

1 2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day 53 PM **Physician** 00 Thomas Hollingowork Russell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA University ot Many land Medical Center Baltmore 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year)
July 29,1924 If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Maryland 81 219-18-2029 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-1 show traumatic avent, the Mudical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 800 Southerly Road 21286 USA Apt. 610 Items 23e Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 Ves 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No ō Specify: Baltimore, Maryland 21215-0036 Specify: þ white 3 Widowed 4 Divorced "netural', Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within in and Mental Hygiene.
7 Is marked othar than "I Elementary/Secondary (0-12) College (1-4or 5+) NASA Aeronautical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Russell McKay Hollingsworth Martin Maude 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ent: If itam 27 Is 800 Southerly Road Apt. 610; Towson, MD 21286 Helen R. Hollingsworth / wife other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Importent: If it any injury or conce. 1 Burial 2 Cremation 3 □ Removal from State 8/12/05 Greek Orthodox Cem. Baltimore, MD Other (Specify) ⁴ 4 □ Donation 22. Name and Address of Facility 21. Signature of Furreral Dervice Ligens 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician dilated cardiomy opathu /Medical Due to (or as a consequence of): Examiner artenu coronary discas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a managuence of by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit aut L stenosis Due to (or as a consequence of) Box 68760 the IF FEMALE: NA
23b. Was decedent pregnant 23d. Date of delivery 23c. If yes, outcome of pregnancy 2 Fetal death 3 Ectopic pregnancy 1 Live birth Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown periorenal vascular dixax Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an emphysems autopsy performed? Yes 2 2 No certificate 1 Yes Division of Vital To the Hospitel or Attanding Physicien: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 ER/Outpatient - 3□ DOA 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? filled in by the funeral 27. Manner of Death Certification: 5 Pending 1 Natural 1 Yes 2 No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 1676

State

31. Date filed (Month, Day, Year) AUG 1 1 2005

MD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22



MD

Registrar

Baltimore

21201

MD

		·	1 - For State Registrar		•	epartment of I Certificate of			Reg. 2 .005	26149
П	Physici		1. Decedent's Name (First, Middle, L 5hinley Rit	1 :	+			2. Date of De Month DB	Day Year	3. Time of Death 5 0130 A M
	/Medio Examin		4a. Fecility Name (If not institution, o	ive street and number)		4b. City, Town,	or Location of	Death	4c. County of De	ath
	Funeral Director		219-28-1384	Sex 7. Ag 1 ☐ M 2 ☐ F	ne (In yrs. last birth 75 Y	Months Days		Min. 8. Date of Bir (Month, Date of Mar. 1	th 4, 1930 Ма	irthplace (State or Foreign Country) ryLand
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Harfo	ord	10c. City, Town	or Location rchville				10d. Inside City Limits 1 ☐ Yes 2X No
	n with the	Funeral Director	10e. Street and Number 711 Priestford 1	Road		10f. Zip Code 21	028		10g. Citizen of What OUSA	Country?
980	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show after must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cut		in? (Specify Yes or No Puerto Rican, etc.)	Black, Wh	nerican Indian, nite, etc. White
21215-0036	- 10	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		5+)	Decedent's Usual Occu Give kind of work done life. DO NOT use retire Oup Head	durina most o	of working	16b. Kind of Busines Insurance	
Maryland ;	be file Ital Hyg Id othe event,	To Be C	17. Father's Name (First, Middle, La Philip William V					's Name (First, Middle y Anthony		
, Mar	od 2 :		19a. Informant's Name/Relationship William G. Heme.		sband 71	1 Priestfo		d, Churchv		21028
Baltimore,	Pages nent of int: If It		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control of the Control	□Removal from State	cemetery	Disposition (Name of crematory or other pla Heart of J		Date 8-12-2005	20c. Location - City of Dundalk, I	
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lic	2		50 W. Bro	adway :	Home, P.A Street, Be	l Air, MD	21014
	Pnysician		shock, or heart failure. Listed Immediate Cause (Final disease or condition	polications that cause thone cause on each I	ine.	et enter the mode of dy	ing, such as c		rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner	L	resulting in death) Sequentially list conditions, if any, leading to immediate	b. neuroer	a consequence of	uman i r	u tousta	on to 1	iver	
00,	death certificate be executed e attending physicien and nd for use as the burial-transit	Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of	,				
68760,	ificate b g physic as the b	edical		d						
O. Box	at the death certific by the attending p tached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 Ectopic pregnand 5 Other (specify)	_{ру}		23d. Date of d Month	elivery Day Year
σ.	ilres this signed d be de	by	Part II. Other significant conditions	contributing to death I	out not resulting in	the underlying cause g	ven in Part I.		tobacco use contribute Yes 2 \(\text{No} \) 3 \(\text{I} \)	to the cause of death? Probably 4 Unknown
of Vital Records,		Completed						24a. Was auto perfo 1 🗆 Yes	psy prior to death	autopsy findings available o completion of cause of
Vita	Phyaician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outp	patient 3 DOA	har	of Death (Check only	one) dence 6 Other (Sp	necity)
ion of	nding Physith.: After this tuneral di	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da		me of 28c, Injury	4 🗀 (40)	28d. Describe	how injury occurred	recity)
Division	spitel or Attending Fours after death. Neral Director: After ifilled in by the funeral.	Certification:	3 Suicide 6 Could not determine	be 28e. Place of In building, e	jury - At home, fam tc. (Specify)	n, street, factory, office		28f. Location (City or To	Street and Number or i wn, State)	Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best aminer: On the basis of and manner s	of examination and	death occurred at the too	ime, date and opinion, death	place, and due to the n occurred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
)	To Test	M	29b. Signature and title of certifier	MO			5 857		29d. Date signed (<i>Mol.</i> 0 9 / 0 9 /	nth, Day, Year)
2	19		30. Name and address of person when the person were person were person when the person were person were person when the person were person when the person were person were person were person which the person were person were person which the person were person were person which the person were person were person which the person were person which the person were person with the person were person were person with the person were person with the person were person were person with the person were person w	mpleted cause of	5:x46	Flour SU	le 2	00 Ba	H. MD	2121)
	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 1 20	437	rar's Signature	Carle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 10b, 19a per fh 9846 8-16-05 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yea **Physician** August 9, Edwin H. W. Harlan, Jr. 2005 12:30 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Charlestown Care Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 15 M 2□ F 212-20-5548 Yrs Director April 21, 1921 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits f Health and Mental Hygiene. Itam 27 is marked other than "netural", or Itams 23a or 28a-1 shov other traumatic event, the Modical Examiner must be natified at 28a-f show Baltimore 1 ☐ Yes 2 ☑ No Director Maryland Baltiore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Maiden Choice Lane USA 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: Specify: Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: ff itam 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ District Court Judge Judiciary 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edwin H. W. Harlan Margaret Hanway ပ 19a. (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlotte B. Harlan wife 717 Maiden Choice Lane; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State = 5 Department o Important: If any injury or Chesapeake Crematory 8/10/2005 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician NEUMONIA WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) tha Hospital or Attending Phyaician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medlcal the t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sivision of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2€ No 1 Tyes 2/2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Tes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Diractor: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide Medical 29a. Certifier #Esertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) V M D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARRET 109 Maiden Choice Ln. TTHEW

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

2005

32. Registrar's Signature

				d / Department of Health and M	lental Hygien	e 2005 06151
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No.	2005 26 5 1 3. Time of Death
13	Physici /Medic		MILTON Jack		JULY 3	30, 2005 11:30A.M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40	c. County of Death
-3	Funeral	- F	BON SECOURS HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs.		8. Date of Birth	9. Birthplace (State or Foreign
÷	Funeral Director		219-32-9134 1×M 20F 69	Yrs. Months Days Hours Min.	(Month, Day, Year March 10,	1936 Dew YORK
	pu 🔪		Usual Residence of Decedent	v. Town or Location		
	shov	7	10a. State 10b. County NA 10c. Cit	y, Town or Location		10d. Inside City Limits 1, Yes 2 □ No
	28a-f	Director	10e. Street and Number	101. Zip Code	10g. C	itizen of What Country?
	3a or	ioi	710 Popular Gr	nest 2/22°	9	USA
	deetl	Funerai	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (Sprif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
980	ges 1 and 2 should be filed within 72 hours after deeth with the Marylend It of Health and Mental Hygiene. If itsm 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic svent, the Medical Exactions must be recitled at	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	Tilodii, dio.j	Specify: Black
21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work)	ing 16b. I	Kind of Business/Industry
121	within ene. than *	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	Factory WORL	. /	varehouses
	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)	1 - 0 - 1 -	e (First, Middle, Maide	n Surname)
ano	ld be i	To Be	(Nalter) fac	han fa	sah	in hight
Maryland	shou and M mari	۳	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	al Route Number, City	or Town, State, Zip Code)
	and 2 salth a n 27 li		Kimberlynn Jackson-daughte	2535 Elesmere	on. wordla	un md. 2/244
ore	of He of He if itsn or oth		20a. Method of Disposyton 1 ☐ Burial 2 Cremation 3 ☐ Removal from State	Place of Disposition (Name of emetery, crematory or other place)	Date 20c. L	Location - City or Town, State
Baltimore	~ = = ~		4 Donation 5 Other (Specify)	tro Crematory 18-11	1-05 (a	Amstile, mg
Bal	permit. Par Department Important: any injury opoce.		21. Signature of Funeral Service Licensee Marcy M. Wallace	22. Name and Address & Facility 3+05 W. Runk Nancy M. Walla		Becto, md, 21229
			23a. Part / Epter the disease, or complications that caused the deat shock, or hear failure. List only one cause on each line.	n. Do not enter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. ATHE ROSCU	PROTIC CARDIOVASCUL	AR DISE	Onset and Death
67	/Medical Examiner		Due to (or as a conseq	uence of):		
2	94). 194)	er	Sequentially list conditions, if any, leading to immediate Due to (or as a conseq	uence of):		
/	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			
oʻ	e exer ien ar urial-t	Ex	resulting in death) Last Due to (or as a conseq	uence of):		
8760,	cale be executed physicien and the burial-transit	dicai	d			
9	E O B	/Me	IF FEMALE: 23c. If yes, outcome of pregna	incy		23d. Date of delivery
Box	that the death certifi ed by the attending detached for use as	by Physician/Me	250. Was decedent pregnant in the past 12 months? 1 \[\subseteq Ves = 2 \subseteq No \] 1 \[\subseteq Ves = 2 \subseteq No \]	I death 3 Ectopic pregnancy		Month Day Year
Ö.	the y th	hys	9 Unknown			
S, P	88 P8		Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I.		use contribute to the cause of death?
of Vital Records,	w require been si should I	Completed		CEREISCUA		2 No 3 Probably 4 Unknown
3ec	has b	mpi	DISEASE		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
a		e Co	25. Was case referred to medical		1 Yes 2 N	
Ē	Physician: r this certific ral director,	To B	examiner?	Othor	h (Check only one) me 5 🗆 Residence	6 Dother (Specific)
10	ding Phy I. After thi funeral		27. Manner of Death 28a. Date of Injury		28d. Describe how inju	
sior	Attending r deeth. ector: After y the fune	atlc	2 Accident investigation	M 1 Yes 2 No		
Division	in the second	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, te)
	To the Hospital or Attent within 24 hours after deet To the Funeral Director: completely filled in by the	edicai C	29a. Certifier (Check out) (C	wledge, death occurred at the time, date and place, tion and/or investigation, in my opinion, death occurr	and due to the cause(s red at the time, date an	s) and manner as stated. Indicates and due to the cause(s)
	o the	Med	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
	⊷ s ⊷ ö		· auets	O.C.M.E.	JULY	Y 31, 2005
•	1	,	30. Name and address of person who completed cause of death (Item	n 23a) (Type, Print)		
	,		ANA RUBIO, MD	111 PENN STREET, BA	ALTIMORE MA	RYLAND 21201
5.4	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 1 2005	foods.		

	1 - State Registrar 1. Decedent's Name		State of ! 23a,25,		a_1 (1)6)	tificate of	Beath"	2. Date of De	aath		26 52 3. Time of Death
ian ical			John E	dward	Jones,	Jr.		August	. 5 Day	^y 2ŎÖ'5	8:20 P M
ner			rive street and number			4b. Cîty, Town, o		ath		. County of Dea	th
	5. Social Security Nu		th Care S		last birthday)	Perry P	O1nt If Under 24 H	rs. 8. Date of Bi		Cecil	thplace (State or Foreign
	216 40 Usual Residence of	2398	1 ∑ M 2□F	61	Yrs.	Months Days	Hours Mi		ay, Year)	943 Ma	ountry) aryland
o.	10a. State Maryland	10b. County	Arundel		ty, Town or Loo Baltimo						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
Director	10e. Street and Nun		ni ulidei		Datting	10f. Zip Code		-	10g. Cit	izen of What C	ountry?
	209 W	. 11th A	Avenue			21	225			U.S.	
Funeral	11. Marital Status		12. Was Decede Armed Force	ent Ever in U	I.S. 13. V	Vas Decedent of h	lispanic Origin?	(Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, Whit	
þ	1 Never Marrie		1 X Yes 2[If Yes, Give Year or Date	□No s:Viet	1	☐Yes 2K No	Specify:	,		Specify: Wh	
iete	(Speci	15. Decedent's fy only highest of	Education grade completed)		(Give	ent's Usual Occup kind of work done	during most of w	orking	16b. K	ind of Business	/industry
Completed	Elementary/Secon	ndary (0-12)	College (1-4	or 5+)	Mech	OO NOT use retire anic	3)		T	ypewrit	er
Be Cc	17. Father's Name (First, Middle, La	st)		1		18. Mother's N	ame (First, Middle	J		
To B		John	Edward J	ones S	Sr.		Ger	aldine K	airi	.s	
	19a. Informant's Na	,	1.51					Rural Route Numb	er, City o	or Town, State,	Zip Code)
			/ sister		_	. 11th A	venue	Baltimo			
	20a. Method of Disp 1 😾 Burial 2		☐Removal from Sta	ite	cemetery, crem	sition (Name of natory or other pla		Date		ocation - City or	
	` 4 Donation			MD		in Cemete		0/2005			e, Maryland
	21. Signature of Fur	erai Service Lic		مملم	- 000.00			Gonce Fu			es as association
-	23a. Part1. Enter th	e disease, or co	mplications that cau	sed the leaf						ie, Mai	yland 21225 Approximate
	shock, or hear	t tailure. List on	ly one cause on each	h line.				ar or roopingtory t			Interval Between Onset and Death
	disease or condition resulting in death)	1		tage I	Dementia	a		<u> </u>	0 0	141	Unknow:
			10 (0.		,						
	Consumption the line of the	ditions	b				A	1 lor	الحالم	MINER	
Iner	Sequentially list con if any, leading to im cause. Enter Under	mediate fying	b Due to (or	as a consec	quence of):		A	elov Myse	EDICAL EX	MANINER	
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ai Examiner	if any, leading to im cause. Enter Under	mediate rlying rijury	с	as a consec			CERTIFICA	PROVED BY M	EDICAL EX	AAMNER	
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State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 7, 2005 12:35 P ^M AUGUST JOYCE A. KELLER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE GILCREST HOSPICE CENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 🗆 M Yrs. Director FEB 12, 1941 173.34.3189 64 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo HOWARD COLUMBIA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10294 NIGHTMIST COURT USA 21044 Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes XX Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ★ ivorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 5+ MATHEMATICIAN US GOVT n and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event spage. Be EVELYN RYDBOM DEVERE BUHITE ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JUNE DeFABIO 6824 WEMBERLY WAY MCLEAN, VA 22101 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition 1 Burial Cremation Themself from State 4 Donation 5 Other (Specify) BAYVIEW CREMATORY 8.8.2005 BALTIMORE, MD Funeral Service 21. Sign # FINK FUNERAL HOME, P.A. GREGORY 426 CRAIN HWY SW GLEN BURNIE, MD 21061 MO1148 Approximate Interval Between Onset and Death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. dy Immediate Cause (Final disease or condition resulting in death) moisoro carrow months Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 Yes 2 Vo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOS P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral is 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0057926 MB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. Charles St. Baltmore and bord mo 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 1 2005 Registrar

15

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ٤, KUCZYNSKI Helen 3:07AM QUOUST 2005 /Medical 4a_Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimure Washington Medical Glan Burnie Anne Arunde If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F 212 22 9655 Director MAD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23a or 28a-1 show other treumstic event, the Modical Examinar must be notified at 10d. Inside City Limits MD BALTIMORE 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 Sycamore Rd USA 21326 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel', or Iten any injury or other treumatic event, the Medical Exami Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☑ Divorced Specify Specify: WHITE þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LINE List UNK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORDECAL ELEANOR BUCKINGHAM RYAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 CENTRAL AR GIENBURNIE MD SICEI WILLIAM LITTLETON OR, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BAYLIEW CREMATORY BALTIMORE * 4 ☐ Donation 5 ☐ Other (Specify) AUE 11, 2005 PANE AND HOUSE FACILITY FINE FAIRNE MD 21061 21. Signature of Funeral Service Licensee as or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part 1 Enter the diseas shock or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metabolic Physician ocidosis dan /Medical Due to (or as a consequence of Examiner acute Lanal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in that of the cause). Due to (or as a consequence of) Examine certificate be executed use as the burial-transit due to E. Cdi and year 212925 that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 ian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Physici 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown signed by to d be detach Parli. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pelvic Kunor with liver metasteses 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, tunor with liver metasteses Completed 3 ☐ Probably 4 ☐ Unknown deep vein thrombosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Š after 4 Homicide filled in 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00022483 august (line) 30. Name and address of person to completed cause of death (item 23a) (Type, Print) 3 as Hospital Dr. Glen Burnie, MD 2106 U A COBS MU 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 1 1 2005

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				For State Registrar	State of	Marylan		artment of F rtificate of		Mental Hyç	giene Reg. N.2 0	05	26156
		Physici		1. Decedent's Name (First, Middle, ALBERT T. KEI						2. Date of Dea Month AUGUST	Day 20	Year 05	3. Time of Death 11:50 P.M
		/Medic Examin	-01	a. Facility Name (If not institution, g		nber)		4b. City, Town, o	r Location of Deal	th		ty of Death	E
\$	- · ·	Funeral Director		5. Social Security Number 6 201–12–6746	. Sex 1 X M 2 ☐ F	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			Cour	place (State or Foreign htry) SYLVANIA
C11.50 Pm		Maryland B-f ehow	ctor	Usual Residence of Decedent	ORE		y, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2 🏋 No
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) Sei	\$. \(\xi\)	ROE G		23a. Part1. Enter the disease, or cashock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on ea	ach line.	h. Do not en	E521 LOCA ter the mode of dying EWDEN	ng, such as cardia	ac or respiratory a	rest,		Approximate Interval Between Onset and Death
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	Examir	ier	Maryland Greneral Hospital Partimore Cit	4	4c. County o	Death
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	with the		10e. Street and Number 10f. Zip Code		10g. Citizen of Wi	nat Country?
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9 X0	es that the death certifi igned by the attending I be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date	of delivery
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P.G	that the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contrib	oute to the cause of death?
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_	other of the comple	Med	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)
	->-0		Meelina Reddy, M.D. 89561		8/8/09	5
	1		30. Name and address of person who completed cause of death (Item, 23a) (Type, Print), Neclima Reddy, M.D. Go Mary land Greneral He	sita.	<u>L</u>	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	7		
	Registr	ar	The state of the s			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Dev Year 9 2005 MARY HOLLY MORAN 5:05 am August 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Locetion of Death 4c. County of Deeth 2409 JERUSALEM ROAD JOPPA HARFORD CO If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) Months Deys Hours 1 □ M 20XF 92 MARÝLAND NOV 10 1912 218-22-0733 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No JOPPA HARFORD CO MARYLAND 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code U.S.A. 21085 2409 JERUSALEM ROAD 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black White etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 XWidowed 4 ☐ Divorced BLACK Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) PRIVATE CUSTODIAN 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) NELLIE DEMBY ISSAC HOLLY 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2411 Jerusalem Rd., Joppa, Maryland 21085 Bernice A. Cottman/Sister 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MT ZION METHODIST CHURCH 08-16-05 JOPPA, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facilit WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive Heart Failure is e consequence of): Hypar Lension Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or as e consequence ol) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, Be Completed by Certification: To i Director: Al filled in by

Physician

/Medical

Examiner

Funeral

Director

Herns 23a or 28a-f ahow ther must be nothed at

Director

Funeral

Completed by

Be

filed within 72 hours after death with the Marylend Hygiene.

ther than "natural", or items 23s or 28s-f show

permit. Peges 1 and 2 should be file Department of Health end Mentel Hy, Important: If Nem 27 is marked oths any Injury or other traumatic event

Physician

/Medical

Examiner

						24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
5. Was case refe	rred to medical				26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☑	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ D0	OA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐Ot	her (Specify)
7. Menner of Dea 1 Natural 2 Accident	th 5 Pending investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	M 2	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occu	rred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stree fy)	et, factor	y, office	28f. Location (Street end Num City or Town, Stete)	ber or Rural Route Number,

To the Hospital o within 24 hours of To the Funeral Di complataly filled ii Medicai

29b. Signature Lunth

00023519

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print) Swith mo obort L

2303 Balain Rd Fall Stom, mD

State Registrar 31. Dete filed (Month, Day, Year) 32. Registrae's Signature

h			For Stete Registrar	State	of Mary		epartmer Certificat			and M	ental Hy	giene	C C	26	159
ı	Physici		Decedent's Name (First, MicELANORE ET								2. Date of Dea	ath Day	2000		ne of Death
	/Medio		4a. Facility Name (If not institu			0.201	-		Location o			_	County of Dea	h	
	Funeral		5. Social Security Number	ARTAN 6. Sex		PITAL n yrs. last birth	day) If Unde	1 Year	If Under 2	24 Hrs.	8. Date of Birt (Month, Day	h Yearl	9. Bir	hplace (St	ate or Foreign
	Director		124-28-3142 Usual Residence of Decedent	1 □ M 2√ F	7	2 Y	rs. Months	Days	Hours	Min.	5/24/1	933		V YORI	K
	aryland show	_	10a. State 10b. Cour	nty	10	c. City, Town	or Location								de City Limits
	the Market 1	recto	MD N	/A		BALTI	MORE CI					10g. Citi	zen of What Co	21	Yes 2□No
	th with 23a or	al Di	6998 MCCLEAN	BLVD.				2123	4			Į	JSA		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In proprient: If item 27 is marked other then "neturel", or items 23a or 28a-f show may highly or other traumatic event, Ite Madical Exacilities and be recilled an ange.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ N 3 ☒ Widowed 4 □ Divorce	If Yes G	orces? 2 📆 No live	r in U.S.	13. Was Dece If Yes, spe		ispanic Orig in, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify:	e, etc.	n,
21215-0036	n 72 ho	Completed	(Specify only hig	lent's Education hest grade completed		1	Decedent's Usu Give kind of wo life. DQ NQT u	rk done d	during most	of working	ng	16b. Ki	nd of Business	Industry	
212	od withinging of the control of the	Somp	Elementary/Secondary (0-12	2) College 2 YEAR	(1-4or 5+) S		.P.N.					HEA	LTH CAR	RE	
Maryland	d be file intal Hy ed oth	Be	17. Father's Name (First, Midd								(First, Middle, JAMERSO		Sumame)		
ary	2 should be and Mental I and Mental I s marked o aumatic eve	To	19a. Informant's Name/Relation	nship (Type, Print)			-		and Numbe	r or Ruma	l Route Numbe	r, City o	r Town, State, 2	Zip Code)	
	1 and 2 Health em 27 ther tra		PHILIP F. RAY	/SON		20b. Place of I	Disposition (Na	me of	1		TIMORE,		21234 cation - City or	Town, Stat	е.
Baltimore,	Pages nent of I int: If its iry or o		1 ☐ Burial 2 🖾 Crematic 4 ☐ Donation 5 ☐ Other		State	cemetery	crematory or o	other plac	- 1	8/1	1/2005		ONSVILI		
Balt	permit. Departn Importe any inju		21. Signature of Funeral Servi	ce Licensed Loto	per		22. Name ai 8521 L					n fi	NERAL I	HOME, 1286	P.A.
	Priysician		23a. Part1. Inter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)		caused the each line.	REN					r respiratory ar	rest,		Approx Interval Onset a	imate Between and Death
68760, <	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and an another prompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit and an another prompletely filled in by the funeral director.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. SEP	TIC FERA	SHOCK SHOCK	ABOON	111/9	AL A	ORT	IC AN)EU	RYSM		
P.O. Box (the death certific y the attending p iched for use as i	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 [nant at time	Fetal death	3 ⊟Ectopic p 5 ⊡ Other (s _t			 ,			23d. Date of del Month	ivery Day	Year
	w requires that the der been signed by the a should be detached f	by	Part II. Other significant cond	itions contributing to	death but n	ot resulting in	the underlying o	cause give	en in Part I.			bacco u es 2[se contribute to □No 3□Pr		of death?
Il Records,	: The law requ cate has been page 2 should	Completed											24b. Were au prior to death?	completion	ngs available of cause of
Zita Zita	sicien certifi irector	o Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☑ No	Hospitals	Inpatient	2 ER/Outp		Oth	25		(Check only of				
Division of Vital	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		27. Mar r of Death Natural 5 ☐ Per	28a. Date	of Injury nth, Day Ye			28c. Injun Worl	at k?	1 2	28d. Describe h		3 □Other (Spe y occurred	эту)	
Divis	tel or Atters after deal of Directors ed in by the	Certification;		ld not be ermined 28e. Place buil	e of Injury ding, etc. (5	- At home, farr Specify)	n, street, factor	y, office		2	28f. Location (S City or Tow		d Number or Ru)	ırai Route i	Vu <i>mber</i> ,
	To the Hospite within 24 hours To the Funeral completely filled	Medical	29a. Certifier 1 Certification (Check only one)	ying Physicien: To the el Exeminer: On the and ma	ne best of m basis of exa nner stated	amination and	death occurred or investigation	at the tin , in my o	ne, date and pinion, deat	d place, a th occurre	and due to the ded at the time, d	ause(s) date and	and manner as place, and due	stated. to the cau	se(s)
	To th withir To th comp	Me	29b. Signature and title of cert	fier			29		e number		- 1	29d. Dat	e signed (Mont	h, Day, Yea	ar)
	,O		30. Name and address of pers	re 141)	ISO Of door	/ltem 22a\ /T	ivne Print	Rt		000)	8	2/02		
_	18		30. Name and address of pers	SIKAZWE	56	01 LC	clt RF	VEN	BLVI	0,13	ALTIM	DRE	MD	2123	9
	Sta Registr		31. Date filod (Month, Day, Ye	on who completed car SIKAZWE ar) 32. 1 1 2005	Registrar's	Signature	Agad	1							

			For	State of Ma	ryland	/ Depa	artment o	f Health	and N	Mental Hy	giene	Legibie.	•
			For State Registrar			Ce	rtificate d	of Deat	h		Reg. No.	005	26160
ı	Physici	an	1. Decedent's Name (First, Middle, La:	st)			Mi	11.50	<	2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give	e street and number)	1	/ /	4b. City, Tox	n, or Location	on of Death	MUCHERY	4c.	County of Dea	5 23.96 ···
		Ŭ.	The Johns Ho	PKins to	105%	Al	1941	timo	20				imore City
ı	Funeral Director		5. Social Security Number 6. \$ 1 236-62-5204	ex 7. Age	i (In yrs. Ias 73	t birthday) Yrs.	Months Da	ys Hour	s Min.	8. Date of Birt. (Month, Day			irthplace (State or Foreign Country)
	Þ		Usual Residence of Decedent		10c. City,					October 2	0, 193	1	West Virginia —
	Manyla 1 shov	JO.	10a. State 10b. County	C:t-	10c. City,	I OWN OF LO) altimar	City				10d. Inside City Limits 1 ▼Yes 2 □ No
	h the l	by Funeral Director	Maryland Baltin 10e. Street and Number	nore City			10f. Zip Cod	Baltimore	City		10g. Citiz	zen of What C	Country?
	ath wil	ralD	2125 St. Paul Street						1218				.S.A.
	fter de ritama	Fune	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent 8 Armed Forces? 1 Yes 2 2 N		13.	Was Decedent If Yes, specify (of Hispanic Cuban, Mexi	Origin? (Sp can, Puerto	pecify Yes or No- Rican, etc.)	` '	Black, Wh	nerican Indian, lite, etc.
99	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 □ Yes 2☑	No Spec	ity:			Specify:	White
15 15	n 72 h "natu	etec	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usual Od kind of work do DO NOT use re	one during m	ost of worl	king	16b. Kir	nd of Busines	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or Itams 23e or 28e-f show ant, I're Madical Examiting the motified at	Be Completed	Elementary/Se <i>co</i> ndary (0-12)	College (1-4or 5	+)		_	/laintena	nce			Mair	ntenance
	be file stal Hy od oths avent,	Be (17. Father's Name (First, Middle, Last)					18. Mo	ther's Nam	ne (First, Middle,		_	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23e or 28a-1 show any injury or other traumatic avent, I'm Marical Examition at the motified at once.	P L	Lee 19a. Informant's Name/Relationship (Moyers Type, Print)		19b. Mailir	ng Address (Sti	reet and Nur	nber or Ru	JUC ral Route Numbe		ullenax Town, State,	Zip Code)
	and 2 saith a n 27 is		Mr. Charles E. Moyers	s Brothe				,	Cabins,	West Virgin	ia 268	355	
Baltimore,	Pages 1 nent of He int: If itan iry or oth		20a. Method of Disposition 1 Surial 2 Cremation 3 C		20b. Plac	e of Dispo netery, crei	sition (Name o matory or other	f place)	1	Date	20c. Lo		r Town, State
Ħ	artmen brtant: injury		'4 ☐ Donation 5 ☐ Other (Specify 21. Signature of uneral Service Lie r		Nort		Memorial		⊡ i λ	/11/2005		Riverto	on, W. Va
Ba	permit. Departr importa any inji		Ollemukok	Dithrush-	POIC	13			,	me Vest Virginia	2680	17	
			23a. Part1. Exter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ent	er the mode of	dying, such	as cardiac	or respiratory an	rest,	,,	Approximate Interval Between Onset and Death
	Enysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Contact	-	2 2/1	of wo	and.	to 9	West			Framediate
	Examiner			Due to (or as a	a conseque	nce of):				11			
	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a consequer	ice of).			1/3	9/ 1		WHER	
	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequer	nce of):			Ψ_{l}	MAPROVEDBY	MEDICAL	Sur	
8760,	ate be e	ical		d					CAT	ON APPROVE			
9	ertifica ding ph	Med	IF FEMALE:	00- 14					EKIM.				
Box	leath certific attending pl	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	Ectopic pregna Other (specify				2	3d. Date of de Month	elivery Day Year
<u>о</u> .	res that the de signed by the a be detached t	hysi	9 🗆 Unknown	9□ Unknown									
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit	by	Part II. Other significant conditions of	ontributing to death bu	ıt not resulti	ng in the u	nderlying cause	given in Pa	rt I.	23e. Did to		/	to the cause of death? Probably 4 □Unknown
Records,	w require been sign	Completed								24a, Wasa			autopsy findings available
	The lav	omo								autop perfor 1 Yes		prior to death? 1 \(\sum \) Ye	completion of cause of
Viita	cien: ertifica ector, p	Be	25. Was case referred to medical examiner?	. Usanitalı					ace of Dea	th (Check only or			
o	Attanding Physicien: The in death. actor: After this certificate had the funeral director, page	1: To	1 ✓ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatien 28a. Date of Injur (Month, Day		VOutpatier Bb. Time o	at 3□ DOA 28c. I	Other: 4 njury at Work?	Nursing Ho	ome 5 Resid			ecify)
ion	anding ath. or: Afte	ation	1 □ Natural 5 □ Pending 2 □ Accident investigation	August 7	O NOT	Injury in Kno	A.A	Work? 1 □ Yes 2	ENO	self in	Flic	TEC	and to chest
Division of	or Attano after death Diractor: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc	iry - At home : (Specify)	e, farm, str	eet, factory, off	ice		28f. Location (S City or Tow	treet and n, State)		Rural Route Number,
	spital nours a naral (29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowle	edge, deat	n occurred at th	e time, date	and place,	and due to the d	rause(s)	and manner a	04/to//bi
	To the Hospital or Attantwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medicel Exam	niner: On the basis of and manner sta	examination	n and/or in	vestigation, in r	ny opinion, o	leath occur	red at the time, o	date and	place, and du	e to the cause(s)
	To To COTT	2	29b. Signature and title of certifier	1. A75	1, 11	10		ense numbe		_ /	29d. Date	signed (Mon	oth, Day, Year)
	10		30. Name and address of person who		ath (Item 2		D.J. O	005			1494	81 8,	0005
	Ψ		Barbara K. Blok	IMD L	N 00	·Wo	fe St	· BA	Him	DRE MAI	LY/A	ind 2	1287
	Cto	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	Θ				-	1		

			1 - For State Registrar	State o	f Marylar		artment o			-	giene Reg. Ne		5 2	6161
	Physici		1. Decedent's Name (First, Middle Mary Jane O'H					-		2. Date of De Month Augus	Da		ear VVS	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution	n, give street and nur	nber)		4b. City, Tov	wn, or Location	of Death	, mojes		. County of		
i	- Funeral	No.	5. Social Security Number 214-12-8613	6. Sex 1□ M 2 F	7. Age (In yrs. 85	last birthday) Yrs.	If Under 1 Y Months D	rear If Under lays Hours	or 24 Hrs. Min.	8. Date of Bi (Month, Di	ay, Year)			ce (State or Foreign
			Usual Residence of Decedent 10a. State 10b. County			ty, Town or Lo	ocation		1	09-02	-191	9 1	Mary]	I. Inside City Limits
	ours after death with the Manylan rai', or Iteme 23a or 28a-1 show Examinar must be notified at	Director	Maryland Balti	more	Ca	tonsvi								1 ☐ Yes 2½ No
	23a or 2	i Dire	10e. Street and Number 602 Woodhurst	Wav			10f. Zip Co				U.S	tizen of Wha	at Country	1?
	after death	Funeral	11. Marital Status	12. Was Dece		.S. 13.	Was Decedent	t of Hispanic C	Origin? (Spean, Puerto	ecify Yes or No Rican, etc.)		14. Race -	American White, etc	
9036	ours afte	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes Go	/e		1 ☐ Yes 2 🗹	No Specify	y:			Specify:	Whit	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then 'natural', or Iteme 23a or 28a-f ehow he Madical Examinar must be notified at	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1	-4or 5+)	16a. Dece (Give life.	dent's Usual C kind of work of DO NOT use r	occupation done during mo etired)	ost of worki	ing	16b. K	ind of Busin	ness/Indus	stry
121	iled wii Hygien ther th	Con	12 17. Father's Name (First, Middle,	(ast)		C1e	rk	18. Moti	her's Name	e (First, Middle		ial Se	ecuri	ty
vlanc	Mental I Merked of arked of	To Be	William H. Kli	nefelter				Ne1	lie G	riffin				
	od 2 sho lth and 27 ls m		19a. Informant's Name/Relations Kathy Yachera		•		ng Address <i>(S.</i> Woodhur							ode)
Baltimore,	permit. Pages 1 and 2 should be filed within Inportant: If Item 27 is marked other than any Injury or other treumatic event, the Manner.		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation		State 20b. F	Place of Dispo cemetery, crea	osition (Name matory or othe	of r place)		Date	_	ocation - Cit		n, State
atim Tim	nit. Pa vartmen ortant: Injury		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service		Ch	-	ke Crem	Address of Fac	dity			tsvill		
Ä	Der Imp		> /holorles	Vinne.		7	1630 E	dmonds	on Av	me of C	aton	nsvil. sville	e, MD	21228
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that of only one cause on e	aused the deal ach line.	th. Do not ent	ter the mode o	f dying, such a	as cardiac o	or respiratory a	arrest,		l Ir	pproximate hterval Between hiset and Death
6	/Medical Examiner		resulting in death)	Due to	or as a consec	10-	omia						6	57 brs
3.	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consec		24176							JC(11_3
<i>₹</i>	cate be executed by sicien and the burial-transit	I Exar	that initiated events resulting in death) Last	CDue to	or as a consec	quence of):								
68760	ificate t g physic as the b	edica		d										
Jane O. Box	The law requires that the death certific ten has been signed by the attending page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2. ② No 9 ☐ Unknown		inth 2 🗌 Feta ant at time of c	il death 3	⊒Ectopic pregr ⊒ Other (specit					23d. Date o Month	-	ay Year
ds, P	uires that signed b	þ	Part II. Other significant condition	ons contributing to d	eath but not res	•	ınderlying caus	se given in Pari	t I.		tobacco Yes 2			cause of death?
Mary Records,	he law requir e has been s age 2 should	Completed	asute re	nal fail	ure						psy ormed?	dea	th?	y findings available eletion of cause of
스 Jital	ysician: The certificate hi director, page	Be C	25. Was case referred to medica examiner?	1				26. Pia	ce of Death	1 Yes		10	Yes 2	∐ No
200	ding Physician: n. After this certifical funeral director,	2	1 ☐ Yes 2 ☑ No 27. Manner of Death			ER/Outpatie				me 5 Res 28d. Describe			(Specify)	
Hanley Vision of Vita	Attending Phyrideath. ctor; After thing by the funeral	ation	1 ⊠Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	of Injury th, Day Year)	Injury	M	Injury at Work? 1 ☐ Yes 2 5				.,		
O' Hanley, Division of Vital	el or Atten s after deat il Director; id in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	286 Place	of Injury - At h ng, etc. (Speci	ome, farm, str	reet, factory, or	ffice		28f. Location (City or To			or Rural F	Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direc completely filled in by	edical C	29a. Certifier 1 Certifyii (Check only one) 1 Medical	ng Physician: To the Examiner: On the b and man	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	th occurred at the investigation, in	he time, date a my opinion, de	and place, eath occurr	and due to the ed at the time.	cause(s , date an) and mann d place, and	er as state I due to th	ed. ne cause(s)
	To th withir To th comp	W	29b. Signature and title of certifie	or			29c. L	icense number	r		29d. Da	te signed (/	donth, Da	y, Year)
	0	1	30. Name and address of person	who completed caus	e of death (Iter	n 23a) (Type.		34388	5283	169X	Au	teng	8,	7005
	70		Jili Halon	en 900	Cata	o Ave		thmore	s, mc	315	929			
	Sta Registi		31. Date filed (Month, Day, Year)	- A	egistrar's Signa	ature	reele							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				epartment of Health and N Certificate of Death		2005	26162
			Registrar 1. Decedent's Name (First, Middle, Last)	Dertificate of Death	Reg.	Ne. UUJ	3. Time of Death
	Physicia /Medic		Edith J. Picha		A uGust	Day 2 Year	8PM M
	Examin		4a. Facility Name (If not institution, give street and number) St. Catherine Nursing Center	4b. City, Town, or Location of Death Emmitsburg		4c. County of Death Frederick	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birth)	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthpi	lace (State or Foreign try)
	Director		509-56-7265		nuary 25,		
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		1)	Od. Inside City Limits
	Maryl -1 ehc	tor	Maryland Frederick Emmits	ourg			1 □ Yes 2 □ No
	th the	Director	10e. Street and Number	10f. Zip Code		. Citizen of What Coun	_
	ath wi	ral	331 S. Seton Avenue	21727		Inited Stat	
936	po-mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importants: If item 27 Is marked other than "naturel", or Items 23a or 28a-1 show attriprior or other treumatic event, the Medical Examinating Indilled at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	 13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify: 	Rican, etc.)	Black, White, Specify: Whi	etc.
5-0	72 ho natur	Completed	15. Decedent's Education 16a. ((Specify only highest grade completed)	Decedent's Usual Decupation Give kind of work done during most of work life. DO NOT use retired)	king 16	b. Kind of Business/Inc	dustry
12	within ine. ihan *	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	iife. DO NOT use retired) nemaker		own home	
d 2	filed Hygie other ent,	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	iden Sumame)	
/lan	uld be Vental Irked Itic ev	To B	John Godar		Angebrand		
Jan	2 sho and I Is ma reuma			Mailing Address <i>(Street and Number or Ru.</i> 305 Caspian Way, New			
e,	1 and Health iem 27		20a Mathod of Disposition 20b. Place of	Disposition (Name of		c. Location - City or To	
E O	Pages ent of nt: If it			criematory or other place) ection Cemetery 08/1	5/05 Ka	nsas City,	Kansas
Baltimore, Maryland 21215-0036	permit. Departminion of the permit of the pe		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Lor 8728 Liberty Rd., Ra	ing Eyers	Funeral D	irectors,In
-	70729		23a. Party Enter the disease, or complications that sused the death. Do n				Approximate
	- V		23a, Party Enter me-disease, or complications in a disease in death. But shock, or heart failure. List only one cause on act line. Immediate Cause (Final	Λ ιΛ .		,	Interval Between Onset and Death
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	Examiner		Sequentially list conditions, b. Utturcelle		sculon	Diens	20 years
	pa sit	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	f):			30-400
	death certificate be executed e attending physician and nd for use as the burial-transit	Examiner	that initiated events c. Due to (of as a consequence of	1):			30 90
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9	artifica ing ph e as th	Med	IF FEMALE:				
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
o.	the y th tohe	hyslo	1 Yes 2 No 9 Unknown				
<u>α</u>	gned gned	by	Part II. Dther significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	cco use contribute to the	he cause of death? pably 4 Unknown
ecords,	> 0 0	ompleted			24a. Was an autopsy	24b. Were auto	ppsy findings available mpletion of cause of
α	r: The favicate has	mo			performe		2100
Vital	Physicien: this certific al director,	BeC	25. Was case referred to medical examiner?	Others	th (Check only one)		7
of	Physic this cral dire	- To	1 Yes 25 No 1 Inpatient 2 ENOUI 27 Manner of Deuth 28a, Date of Injury 28b, T	ime of 28c. Injury at	ome 5 Residence 28d. Describe how	ce 6 Other (Specification)	у)
lon	Attending In death. ector: After by the funer	atlon		njury Work? M 1 ☐ Yes 2 ☐ No			
Division	of or Attendia after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town,	et and Number or Rura State)	al Route Number,
	Hospite 4 hours Funere ely fille	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge 21 medical Examiner: On the basis of examination and analysis of examination and analysis of examination and analysis.	death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as s and place, and due to	tated. o the cause(s)
	To the within 2. To the Complet	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)
)	X		I Cla Calloll	M) 1)18705		8 9 0	15
	6		30. Name and address of person who completed cause of death (Item 23a) (itahuma 1	vm 21727	
_		ate	Alan Carroll, M.D., 310 S. Seton Av 31. Date filed (Month, Day, Year) 32. Pgistrar's Signature	e., PU BOX 3U9, Emm	respurg, r	ш 41/4/	
	Sti Benist		AUG 1 1 2005 Regues 15.	a could			

Division of Vital Records, P.O. Box 68760,

	•	For State Registrar	Olaic of Wi		Department of I Certificate of			eg. N2 0	05	26163
ıysiciaı	n	Decedent's Name (First, Middle, Document of the control o					2. Date of Dea Month		Year	3. Time of Death
Medica	al .	MADELINE J. 4a. Facility Name (If not institution,	PYLES		4h City Town	or Location of Death	August	40 COU	2005	19:31 M
kamine	er	Sinai Hospit		timore		imore C		40. 000	N A	
neral ector		5. Social Security Number 579.09.0369 Usual Residence of Decedent		e (In yrs. last birt 37	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day	Year)	9. Birthpla Countr	DC (State or Foreign
ם	1	10a. State 10b. County		10c. City, Town	or Location				10	d. Inside City Limits
at must be notified at	Director		A	BALTIM	ORE					1 ☑Yes 2 ☐ No
De re		10e. Street and Number	1000 2500		10f. Zip Code	00			of What Countr	y?
INC TUBE	Funeral	2606 N. LONGY	12. Was Decedent		13. Was Decedent of I	1216 Hispanic Origin? (Sp	pecify Yes or No-		USA Race - America	n Indian,
Indiana.	<u> </u>	1 Never Married 2 Marrie	Armed Forces? 1 Yes 2 11 if Yes, Give	No	If Yes, specify Cub	oan, Mexican, Puerto	Rican, etc.)		Black, White, et	
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	5 5	12 TH GRADE	3 YRS)+)	CLERK			SOCIAI	L SEC	LRITY
avan	Be	17. Father's Name (First, Middle, L	,			18. Mother's Nam			ame)	
matic	0	RICHARD WILLIAM 19a. Informant's Name/Relationsh		19b.	Mailing Address (Street	MADELIN t and Number or But			vn State Zin (Code l
ar trau	4	JOHN PYLES	(HUSBAND)		06 N. LONG		BALT		. 0	
or oth		20a. Method of Disposition 1 🗷 Burial 2 ☐ Cremation	3 DRemoval from State	20b. Place of	Disposition (Name of v, crematory or other pla		-		n - City or Tow	n, State
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any ir		21. Signature of Funeral Service L	icensee							
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	+	23a. Part 1. Enter the disease, or c	complications that caused	the death. Do n	5151 BALTO.	NATU PIKE	BAUTO . I	ance No 212	29	Approximate
zian.		23a. Part 1. Enter the disease, or o shock, or heart ailure. List o	inly one cause on each lir	10.	5151 BALTO.	NATU PIKE	BAUTO . I	ance No 212	29	Approximate Interval Between Onset and Death
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State Registrar

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Baltimore

		. For		of Marylar						-			
	•	1 - State Registrar			Ce	rtifica	te of	Death			Reg. No.	2005	26/64
Physicia	,	Decedent's Name (First, Middle, L.	ist)							2. Date of De Month	aath Day	Year	3. Time of Death
/Medic	al .	Shantaben N. Pa				4b Cib	. Tourn	or Location o	f Do ath	Aug	7	දිප ය ⊆ County of Dea	
Examine	er	4a. Facility Name (If not institution, gi 6251 Washington 1		imber)			ridg		Deam		10.	Howar	
Funeral	-	5. Social Security Number 6.	Sex	7. Age (In yrs.	last birthday	+	er 1 Year		24 Hrs. Min.	8. Date of Bir (Month, Da	th av. Year)		thplace (State or Foreign ountry)
Director	}	590-62-5918	1□M 252TF	74	Yrs.	I I I I I I I I I I I I I I I I I I I	Julys	110010		June 1,			
puel man	1	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or L	ocation							10d. Inside City Limits
Mary 9-1-8-h	jo	MD Howard		E	Lkridge	2							1 ☐ Yes 2 反 No
death with the Marylend ims 23a or 28e-f show rmast be notified at	Director	10e. Street and Number					ip Code				10g. Citi	izen of What Co	ountry?
a 23a		6251 Washington		and ant Ever in 1	16 12		1075	licoanio Orio	nin? (Sne	acity Vas or No		ritan 14. Race - Amo	erican Indian
P 55 52	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed F	2 No					, Puerto	ecify Yes or No Rican, etc.)		Black, Whi	te, etc.
C Z1Z15-UU36 filed within 72 hours after death with the Maryler Hygiene. other than "natural", or Itams 23s or 28e-1 show ant, the Madical Examiner man be notified at	ğ	3 Widowed 4 Divorced	If Yes, G Year or	ive			2√∏ No		Asi			Specify: As	sian
72 hc	Completed	15. Decedent's E (Specify only highest g	ducation ade completed)	16a. Dece	dent's Us	ual Occup	nation during most d)	of worki	ing	16b. Ki	ind of Business	/Industry
Maryland 21215-0035 d 2 should be filed within 72 hours at th and Mental Hygiene. 7 is marked other than "natural; or treumatic event, the Medical Exern	dmo	Elementary/Secondary (0-12)	College	1-4or 5+)		make		0)				Home	
ING 21215-U be filed within 72 ho kal Hygiene. d other than "natur event, the Medical	Be	17. Father's Name (First, Middle, Las	t)		Home	marco		18. Mothe	r's Name	(First, Middle	-		
should be ind Mental marked o	2	Lallubhai M. Pat								Dahyabh			
Maryica d 2 should th and Mer 7 is marke treumatic		19a. Informant's Name/Relationship Girishbhai Patel-				171				u Route Numb	er, City o	r Town, State,	Zip Code)
C = 44 F		20a. Method of Disposition		20b.	6251 Place of Disponentery, cre	Wash	ingto	on Blv	rd. I	Elkridg		aryland ecation - City or	
		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from						ıg. I	10, 05	BA1t	imore C	lity
Baltimo permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	nsee	'(a !								imore C neral H	
n saesa		MM XICH	Vari	que					-			Marylan	d 21229
		23a. P. 11. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one caus (o	each line.	th. Do not en	ter the mo	ode of dyli	ng, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a	(or as a conse		arry.	them	195	<u> </u>				IHR
Examiner		Convention to East accorditions		4 there.		tic	heam	L chis	ear	e			54-5
/p ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consec	quence of):								
and and III-tran	Examiner	that initiated events resulting in death) Last	c	(or as a conse	quence of):								
Sicie ab	calE	(d										
BOX 68,		IF FEMALE:											
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. 0 0 0	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Preg 9⊟ Unki	nant at time of nown	death 5	Other (specify)						
	by Ph	Part II. Other significant conditions	-		-		cause giv	en in Part I.		23e. Did	tobacco u	ise contribute to	o the cause of death?
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law range be a 2 sh	Completed									24a. Was	an psy ormed?	prior to	utopsy findings available completion of cause of
										1 ☐ Yes	2 D No	death?	2 1 No
	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	TER/Outpatie	nt 3□ [OOA Ott	201		me 5 Wes		6 □Other (Spe	ncifv)
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DIVISION O Let or Attending Pr s after death. el Director: After tl ed in by the funera	Certification:	4 Homicide determine	4 Z00, Flac	e of Injury - At I ling, etc. (Spec	nome, farm, st ify)	reet, facto	ory, office			28f. Location (City or To			ural Route Number,
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To the within 2 To the complet	Σ	29b. Signature and title of certifier	1.			2	9c. Licens	se number				te signed (Mon	th. Day, Year)
				DESIH A		Priot'		0300	494		8	18105	
4		30. Name and address of person who		nicles of			8	altim	kore-	MO X	عدي	•	
Stat		31. Date filed (Month, Day, Year)	32.	Registrar's Sign		1							
Registra	r	AUG 1 1	2005	3 108 145 A	15.	to the said	2						

			For State	State of Maryland	-				~ ~		
		- 45	Registrar 1. Decedent's Name (First, Middle, Last)		Cent	ificate of L	Jeath	2. Date of Dea	Reg. No	05	26165
- 47	Physici	an	Charles	F	PLA	TER		Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give stre				Location of Death	Augus	st 8, 20		12:35 P [™]
1	Examin	iei	144 Siegwart Lane	,		Baltimor				1/4	
16	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth	h Vaarl	9. Birthpla	ace (State or Foreign
	Director		210-60-5617	^{2□} F 51	Yrs.	Months Days	Hours Min.	(Month, Day	54	Count	8.
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loca	ition				10	d. Inside City Limits
	Maryi f sho	ō	ND. NA	_	LTIN						1 XYes 2 □ No
	288-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Count	rv?
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21215-0036	hours after death with the Maryland tural, or Items 23a or 28a-f show al Exerciter count tencellised at	by Funerai	11. Marital Status 12. 1 Never Married 2 Married 3 Narried 3 Divorced	Was Decedent Ever in U.S. Amjed Forces? 1 Layes 2 □ No If Yes, Give Year or Dates:	lf Y	as Decedent of Hi es, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - America k, White, e	tc.
2-0	72 hours 'natural', orcel Exe	ted	15. Decedent's Educati (Specify only highest grade co	on 16	6a. Deceder	nt's Usual Occupa	ution	vin a	16b. Kind of Bu	ısıness/Indu	ıstry
21	be filed within 72 hotal Hygiene. d other then "netunevent, the Models"	Completed		College (1-4or 5+)	lite QC	NOT use retired,		ang	HOME	ZMP.	COVEMENT
	il Hygier other th		12	-0-	~ ~ ~						CVEMOCI
Maryland		Be c	17. Father's Name (First, Middle, Last) MORRIS	ATER			18. Mother's Nam		Maiden Sumami ZHER	,	
Z	d 2 should th and Mer 7 is marke traumatic	2	19a. Informant's Name/Relationship (Type,	Print) 1	9b. Mailing	Address (Street a	nd Number or Rus				Codel
M	nd 2 alth ar 27 is r trau		SAllie Plater.				am bRA				21212
ore,	ges 1 and t of Healt If Itam 2 or other		20a. Method of Disposition	20b. Place	of Disposit	ion (Name of tory or other place		Date	20c. Location -		
Ē	Pages ment of ant: If It ury or o		1 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)		RISON	FORES!	. R(10	105	wing	rille,	ND.
Baltimore	permit. Pag Depertment Important: I any injury o		21. Signature of Fluneral Service Licensee	CPC	22. N	Vame and Address	s of Facility L	hellip	5 Fring	val 14	me
* 2			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of	ons that caused the death. D						,	Approximate nterval Between
	Physician /Medical Examiner	L.	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence		PLICATING	- HYPERS	TENS (VE	MR DISEA		Onset and Death
	ted nsit	Examine	Cause (Disease or injury	Due to (or as a consequence	28 OI):						
<u>,</u>	be executed ician and burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a consequence	e of):						
8760	cate be ex physician the buria	dical	d								
9		0	IC CEMALE.								
.O. Box	law requires that the death certific as been signed by the attending p . 2 should be detached for use as	Physician/M	in the past 12 months?	If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 9□Unknown		ctopic pregnancy other (specify)			23d. Date Mon	e of delivery oth D	/ Day Year
٣.	res that igned b	by P	Part II. Dther significant conditions contrib	uting to death but not resulting	g in the unde	erlying cause give	n in Part I.	23e. Did tol	bacco use contri	bute to the	cause of death?
ird	w require been sig should b				-			1 □ Ye	es 2 No	3 🗌 Probat	oly 4 donknown
Division of Vital Records,	The ate h page	Completed						24a. Was a autops perform	med? de	rior to comp eath?	sy findings available pletion of cause of
Vita	ding Physicien: Th n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	ital.			26. Place of Deatl				
ot	Phys this ral dir	2	1 1 Yes 2 □ No Hosp 27. Manner of Death 2	1 Inpatient 2 ER/C	Outpatient Time of	3 DOA Cine	4 Nursing Ho				at scene
on	ding Afte fune	Certification:	1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day Year) 818/05 (FUV) Fou	Injury	28c. Injury Work'	es 2 No	28d. Describe ho	LUBRED /	N HIG	H
/ISI	after deatl Director:	fica	all Could not be	8e. Place of Injury - At home, building, etc. (Specify)				28f. Location (St			OUTE Number.
ā	s after s after al Director	Cert	4 Holflicide	RESIDE W				City or Town		1 BAL	TIMORE, MD
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	edical (29a. Certifier (Check only one) 1 Certifying Physicia Check only one)	in: To the best of my knowled On the basis of examination a and manner stated.	lge, death or and/or inves	ccurred at the time tigation, in my opi	date and place	and due to the co	auso(s) and man	nor as stat	nd
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed	(Month, Da	ay, Year)
)	1 1		aried _			O.C	.M.E.	A	ugust 9	, 200	5
4	542		30. Name and address of person who compl ANA WYSIC	eted cause of death (Item 23a			eet, Bal	timore,	Maryland	d 212	01
	Sta Registra	-	31. Date filed (Month, Day, Year) AUG 1 1 200	32. Resistrar's Signature	K A	arle					

		1 - For State Registrar		ryland / Dep	artment of Health and artificate of Death	Mental Hyg	_	
Physici /Medi		1. Decedent's Name (First, Middle, Last) ANTHONY R.	Rooms	quEZ		2. Date of Dea Month AUGUST	Day Year	- 1544 M
Examir Funeral Director	ier	5. Social Security Number 6. Sec	AYUSEW ME	(In yrs. last birthday	If Under 1 Year If Under 24 H	Irs. 8. Date of Birth in. (Month, Day	(Year)	eth inthplece (State or Foreign Country) 11.fornia
e Maryland Sa-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	е	10c. City, Town or L	own			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
be filed within 72 hours after death with the Maryland stall Hygiene. Ital Hygiene. Ital Hygiene flam and train or iteme 23a or 28a-f ehow event, the Medical Examinat multipe multiple at	y Funeral Director	10e. Street and Number 9908 Oak Glen Re 11. Marital Status 1 □ Never Married 2 ☼ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give	ever in U.S. 13.	10f. Zip Code 21133 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 △Yes 2 □ No Specify: M.	U	14. Race - Am Black, Wh	es of America
illed within 72 hours after Hygiene. Wher then "natural", or ite natural", or ite medical Examina	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	Year or Dates: cation e completed) College (1-4or 5-	+) (Give	edent's Usual Occupation e kind of work done during most of t DO NOT use retired) CCT Manager		16b. Kind of Busines	
should be filed within and Mental Hygiene. I marked other than umatic event, tra Me	To Be Co	17. Father's Name (First, Middle, Last) Arthur Rodrique	2	Ţ	18. Mother's N	Name (First, Middle,	Maiden Surname)	
and 2 shu and 2 shu lealth and m 27 is m		19a. Informant's Name/Relationship (7) Cheryl Rodriquez 20a. Method of Disposition	(Spot	1se) 9908	ing Address (Street and Number or Oak Glen Road, osition (Name of smatter) or other place)			and 21133
permit. Pages 1 Department of H Important: if ite any injury or ot		1 Burial MCremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Furior of Service Licens		Mt. Comfo	ort Crematory 08/ 22. Name and Address of Facility C 728 Liberty Road	ring Byer	s Funeral	
Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin a. PU	the death. Do not ere. MONA a consequence of):		TFNJ 507		Approximate Interval Between Onset and Death 4 MONTHS
be executed iician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):				
death cert e attending of for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of d Month	elivery Day Year
requires that the	þ	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the	underlying cause given in Part I.			to the cause of death? Probably 4 DUnknown
The lay	Completed				20 Plant 44	24a. Was autop perfor 1 Yes	sy prior to death?	autopsy findings available completion of cause of second 2 No
Phys this	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day		ent 3 DOA Other: 4 Nursin	g Home 5 🗆 Resid	dence 6 Other (Sp.	pecify)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	i Certification;	3 Suicide 6 Could not be determined	building, etc			City or Tow		
To the Hoep within 24 hou To the Fune completely fi	Medicai			examination and/or i	ath occurred at the time, date and pl nvestigation, in my opinion, death o	ccurred at the time, o		ue to the cause(s)
87		Ohin Organia.			AF266 4200 -	F339	AUGUST 9	1,2005
St	ate	Christopher Inge 31. Date filed (Month, Day, Year) AUG 1 1 2	1mo, MD 49	1- 6'	n Avenue, Baltin	nore, MD 2	1224	

			1 - For State of Maryland / Department State Registrer	artment of Health and M		ene	26167
	Physic		1. Decedent's Name (First, Middle, Last) Charles William	Reinke	2. Date of Death Month August	8 ^{ay} 2005	3. Time of Death 2:00 P M
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 1201 Montgomery Drive	4b. City, Town, or Location of Death Glen Burnie		4c. County of Dea	th
ļ.	Funeral Director		5. Social Security Number 217-20-5255 Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) 7-18-192	rear) Co	thplace (State or Foreign ountry)
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then the marked other then "natural", or Items 23e or 28e-f show other traumatic event, Ira Medical Exertiret matcher colling at	by Funeral Director	1 Never Married 2 AMarried 12 Yes, Give 1946 - If Yes, Give			g. Citizen of What Co U.S.A. 14. Race - Ame Black, Whit Specify: W	erican Indian,
Maryland 21215-0036	ad within 72 hour rgiene. er then "natural t, Ir a Medical E.	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) ker	ng 16	Sb. Kind of Business Banki	ŕ
ryland	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, It e Ms	To Be (17. Father's Name (First, Middle, Last) William Gerhart		lea Weich	eser	
Baltimore, Mar	permit. Pages 1 and 2 sh Department of Health and Important: If tiem 27 Is n any Injury or other traum <u>once.</u>		Mrs. Pearl F. Reinke / wife 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	matory or other place) Park Cemetery 8-12 2. Name and Address of Facility Sin	Glen B 20 20 20 3 -2005 G agleton F	urnie, MD c. Location - City or wynn Oak, uneral Ho:	21061 Town, State Maryland me P.A.
Į,	Friysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liesase or the fury that initiated events)	1 Second Ave SW, Geter the mode of dying, such as cardiac o			Approximate Interval Between Onset and Death
Box 68760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	Physician/Medical Examiner	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of del	ivery Day Year
P.O.	res that the de igned by the a be detached f	by	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the u	Other (specify)ndertying cause given in Part I.		cco use contribute to	the cause of death?
l Records,	The law requires that ate has been signed b page 2 should be deta	Completed			24a. Was an autopsy performe	d? _ prior to death?	obably 4 Monknown Itopsy findings available completion of cause of
sion of Vital	Physician: r this certific ral director,	ation: To Be C	25. Was case referred to medical examiner? 1		(Check only one)	ce 6 □Other (Spe	73/
Division	ire ire	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town, S		
	To the Hospitel of within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
)	- 1-		> man m. D	D 39505	A	ngusl	9,2005
	Į D Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Your Sharps Superior Sharps S	29c. License number D 39505 Print) LOSpital M. G	len Bu	vmie,	21061
	Registr		AUG 1 1 2005 Seem B. Ag				

			For State Registrar		aryland / Dep		Health and	Mental Hyg	•	
		休	Decedent's Name (First, Middle, Last,	1		Timeate c	Dealii	2. Date of Deat		
	Physici	an	Joseph Harris (7 Wat, 1990)B, East,	Rul	Po	ark		Month	Day Year	
	/Medi		As Escility Name (If not institution with		7, 10			August	9 2005	10:00 P.M
	Examir	ier	4a. Facility Name (If not institution, give Genesis Elderca				n, or Location of Dea		4c. County of De	
			5. Social Security Number 6. Sec		(In yrs. last birthday		verna Par		1	Arundel
	Funeral Director			M 20XF	89 Yrs.	Months Day			Year) 916 V	irthplece (State or Foreign Country) irginia
			Usuel Residence of Decedent		0,			11011 . 17	, 1310 1.	11 6111111
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mar P-f st	ţo	Maryland Baltimo	re	Lansdo	wne				1 ☐ Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Cod	9	10	Og. Citizen of What C	Country?
	filed within 72 hours after death with the Maryland Hygiene yther than "natural", or liems 23a or 28e-1 show ont, the Medical Examinar hust be notified at	ai D	200 - 1st Avenu	ıe		2	1227		U.S.	
	dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of	f Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Am	
9	or He	E	1 Never Married 2 Marned	1 ☐ Yes 2 ☑ N	ło	1 ☐ Yes 2X N		rto rican, etc.)	Black, Wh	
ဋ္ဌ	ours eral',	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:		TLITES ZEUT	lo Specify:		Specify: W	nite
5	72 h 'natu	Completed	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i>	16a. Dece	dent's Usual Oct	cupation ne during most of wi ired)	orkina	16b. Kind of Busines	s/Industry
7	Atthin	ıμ	Elementary/Secondary (0-12)	College (1-4or 5	+1		ired)		D.	
2	led v tygie her t		12th		wai	tress			Restaura	ant
ng	be fi	Be	17. Father's Name (First, Middle, Last) Charle	es J. Wall	en		1	ame (First, Middle, M die F. Ro		
$\frac{8}{5}$	should and Men a marke umatic	2					<u>L</u>			
Maryland 21215-0036	12 st h and 7 Is n traun		19a. Informant's Name/Relationship (Ty. Mary Scanlon	pe, Print)				Rural Route Number,		
e)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic avent, the Medical Experience with be notified at ance.		20a. Method of Disposition			Phirne		len Burnio		
Baltimore,	Pages nent of I nnt: If its		1 3 Burial 2 ☐ Cremation 3 ☐ A	lemoval from State	20b. Place of Disponentery, cre	matory or other p			Oc. Location - City o	r rown, State
	rtmer rtent rjury		*4 □Donation 5 □Other (Specify)	*	Loudon P				Baltimore,	
Ba	permit. Departr Importe any inju		21. Signature of Funeral Service License	90		2. Name and Add		Gonce Fune		
			23a. Part 1. Enter the disease, or compli	unus	urfer 4	001 Rite	chie High	way Balti	more, Mar	yland 21225
			snock, or neart failure. List only or	ne cause on each lin	e.	ter the mode of d	ying, such as cardia	ic or respiratory arre	ST,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Non Ho	lakin's	Lyma	shoma			140
ĸ	Examiner			Due to (or as a	consequence of):					
	S. Donat	-	Sequentially list conditions, if any, leading to immediate		consequence of):					
7	ted nsit	nin	Cause (Disease or injury	(0.00						
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
760,	sicial suri	cail								
89	death certificate to attending physical for use as the to									
×	nding use a	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of					23d. Date of de	livery
m	death a atte	Ca	in the past 12 months? 1 ☐ Yes 2 No	1 ☐ Live birth :		Ectopic pregnar Other (specify)	ncy		Month	Day Year
P.O. Box	t the	hys	9 Unknown	9□ Unknown						
(C)	The law requires that the death certifica tte has been signed by the attending ph. bage 2 should be detached for use as th	by Physician/Medi	Part II, Other significant conditions con	tributing to death bu	t not resulting in the u	nderlying cause (given in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
Division of Vital Records,	w require been sig should b	pe p						1 🗆 Yes	2 □ No 3 □ P	robably 4 Unknown
ပ္သ	s bee	Completed						24a. Was an	24b. Were a	utopsy findings available
ž	The lay te has age 2	EO						autopsy perform	ed? death?	completion of cause of
ē	Physician: The la r this certificate has ral director, page 2	O	25. Was case referred to medical				26. Place of De	1 ☐ Yes 2/ ath (Check only one	9	s 2 No
>	ysici is ce direc	ToB	examiner? 1 ☐ Yes 2 No	ospital: 1 Inpatier	t 2 ER/Outpatier	nt 3□ DOA C	at.	Home 5 ☐ Resider		acify)
0	ng Ph ter th neral		27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time o			28d. Describe how		,
<u> </u>	ath. ath. or: Af	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(injury		Yes 2 □ No			
§ ≥	l or Attending Physician: after death. Director: After this certifics in by the funeral director, i	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	y - At home, farm, str (Specify)	eet, factory, offic	9	28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
	ital o	Cer						10		
	Hosp 4 hou Fune ely fil	ca	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of	my knowledge, deat	n occurred at the	time, date and place	e, and due to the cau	ise(s) and manner a	s stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	Medical	0.10)	and manner stat	ed.					
	To To	-	29b. Signature and title of certifier				nse number		d. Date signed (Moni	
			Kenul Du	42			1660	A	scust 10	0, 2005
	3		30. Name and address of person who cou				Bultim	and their	2123	
			Robert C. Durt	Sr. 90		- two.	MINIM	שוד עוני	125	<u> </u>
	Sta Registra		AUG 1 1 200	2	s signature	rade				

			1 - For State Registrar	State of I	Maryland / [•	artmen <i>tificate</i>			and M	_	giene Reg. NG. (005	2616	. 0
	Physic		1. Decedent's Name (First, Middle	Du Roda	Š						2. Date of De Month	- Colonge	Yeer 2005	3. Time of E 9:25 a.	Death M
	/Medi Exami		4a. Facility Name (If not institution		er)		4b. City,	Town, or	Location o			1	ounty of Death		
			5. Social Security Number	Beaverbrook C	orner Age (In yrs. last bii	thday)	lf Under	1 Year	If Under:		Imbia 8. Date of Bir	eb.		ward	<i>C</i>
	Funeral Director		283-24-5902	1□M 2XF		Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		nplace (State or untry)	
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow						August 3	J, 1928	P.	ennsylvania	
	the Marylar 28a-f show collified at	ō		Howard	10c. City, 10w	n or Lo	cation	E10	11 0'1					10d. Inside City	
	r 28a-	Director	Maryland 10e. Street and Number	Howaru			10f. Zip		cott Cit	у		10g. Citize	on of What Co		
	th with		2803 Green Shade	Ct.					210	42			U.S	.A.	
36	be filed within 72 hours after death with the Maryland Ital Hygiene. Id ether than "natural", or items 23s or 28s-f show event, it a Medical Evaning must be rotified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	12. Was Decede Armed Force ied 1 Yes 2 If Yes, Give Year or Date	No.		Vas Deced Yes, spec	. 4	spanic Orig , Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	İ	Black, White		
2-0	72 hou	ted	15. Deceden	's Education			ent's Usua					16b. Kind	d of Business/l	ndustry	
Baltimore, Maryland 21215-0036	within 7 ene. than 'r	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4c	or 5+)	life. [kind of wor OO NOT us	e retired)			ng		Own	Home	
2	filed w Hygier other ti		17. Father's Name (First, Middle,	l ast)					emake		(First, Middle,	Maidon C	umamal		
lan		To Be		eph A. Tvson					IO. NIOLIIO	1 5 Name		eline Di			
ary	d 2 should th and Men 7 ie marke traumatic	-	19a. Informant's Name/Relations		19b	. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Numbe			ip Code)	
Σ	C = N L		Mr. Donald Rodis,	Jr. So					ade Ct.		tt City, Ma	ryland 2	21042		
lore	000		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from Sta	20b. Place of cemeter	f Dispos ry, crem	sition (Nam natory or ot	e of her place	,		ate		ition - City or T		
Ħ			* 4 □Donation 5 □ Other (S) 21. Signature of Buneral Service		Fo	-	Lawn C				3/2005		Youngsto	wn, Ohio	
Ba	permit. Departn Imports any Inju		Mandellen !		سردر		SI	ack Fu	neral E	lome	P.A. ike Ellicoti	City NA	ID 04040		
	rnysician /Medical Examiner	er	23. Part1. Enter the disease, or shock, or heart failure. List mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate caus. The shock of the cause (Disease or injury)	Due to lor a	as a consequence	of):	nfar	1 2 -		Jan Grado O	i rospiratory at	, 631,		Approximate Interval Betwee Onset and De	een eath
W	cuted nd ransit	Examiner	that initiated events	C											
8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due to (or a	as a consequence	of):									
9	ertifica ing ph e as th	1 0	IF FEMALE:											-	
.O. Box	at the death certificate be executed by the attending physician and tached for use as the buriat-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		2 Fetal death at time of death		Ectopic pre Other (spe					230	d. Date of deliv Month	ery Day Ye	ar
rds, P	ires the signed d be de	by	Part II. Other significant condition	ns contributing to death	but not resulting in	the un	derlying ca	use giver	in Part !.			bacco use es 2 🗆 l		the cause of dea	
Records,	e law hes b je 2 sl	Completed									24a. Was autop perfo	sy	24b. Were auto prior to co death? 1 Yes	opsy findings avanthement of cau	ailable ise of
Vital	Physiclan: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Montheli						of Death	Check onl o		Acs-11	Alterest	
of	S S	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of In		tpatient ime of		Other	4 LI NUI		ne 5 Resid	_		(y) J	
Division	To the Hospital or Attending Ph within 24 hours eiter death. To the Funeral Director: Atter th completely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation (Month, L	Day Year) Ir	njury	М	Work? 1 □ Ye	es 2 🗆 N	lo	8d. Describe h				
Δ	oital or A urs efter eral Direc	Certif	4 Homicide determine	building,	njury - At home, far etc. <i>(Specify)</i>						City or Tow	n, State)		al Route Numbe	97,
	To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the I	Medical	one)	g Physician: To the bes xaminer: On the basis and manner:	or examination and	, death d/or inve	estigation,	in my opir	nion, deatr	place, a n occurre	d at the time, o	date and pla	ace, and due t	o the cause(s)	
}			29b. Signature and title of certified	5 m.o.				License I				S/I	igned (Month,	uay, Year)	
	3		30. Name and address of person w	vho completed cause of	death (Item 23a)	Type, P	rint)	er 1	12	6,1€	n Bur	nie, v	no 21	060	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	Car	del								
DHI	MH 17 Rev 1/2		AUG 1 1	WUD CUU	2 70	-									

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. 2.005 26 70
	Physic /Med		1. Decedent's Name (First, Middle, Last) Rarl Robert Stepp 2. Date of Death Month Day Year 7 9: 40 A M
	Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	. Funeral Director		Atlantic General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 1 M 2 F
	aryland show	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	death with the Marylanns 23s or 28e-f show	Director	MD Worcester Berlin 1 □ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	23s or	al Di	46 Anchor Way Drive 21811 United States of America
036	ours after or ai', or iter	by Funeral	11. Marital Status 1
21215-0036	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene item 27 is marked other than "natural; other traumatic avent, the Medical Ex-	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 B of Electrial Workers
nd	be filec ital Hyg id othe avent,	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Maryland	12 should be 1 and Mental I is marked or raumatic ave	2	Leo Balto Stepp Esther Gertruide Fix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
, ⊠	and 2 stalls are 127 is er trau		Mrs. Lois Stepp 46 Anchor Way Drive, Berlin, Maryland 21811
Baltimore,	eg = 5		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)
atin	permit. Pa Dej artmen Important: any injury		Lake View Memorial Pk 08/11/05 Sykesville, Maryland 21. Signature of Funeral Sarvice Libensee 22. Name and Address of Facility Loring Byers Funeral Directors, Ir
B	Dermi Der a Impro any ii		8/28 Liberty Road, Randallstown, Marvland 21133
	Physician /Medical		23 art1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) a
8760,	certificate be executed rding physician and sea the burial-transit	lical Examiner	Sequentially list conditions, dark, loading to him oldate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Subject to (or as a consequence of): c. Due to (or as a consequence of): d
.O. Bc	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
rds, P	ires sign 1 be	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Probably
Vital Records,		e Completed	24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Chark and autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of	S D	To B	25. Was case referred to medical examiner? 1
Division	tal or Attencts after death at Director:	Certification;	3 Suicide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
)	Tomo	M	29b. Signature and titile of certifiery 29c. License number 29d. Date signed (Month, Day Year) 8/7/05
1			30. Name and address of person who completed cause of feath (Item 23a) (Type, Print) Robert Dur (in 9733 Hz) / Thurry Berlen, MD 31. Date filed (Month, Day, Year) AUG 1 1 2005 32. Desistrar's Signature
	Sta Registr		31. Date filed (Month, Day, Year) 32. Posstrar's Signature 32. Posstrar's Signature

317-30-1634

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 5 per fn 8846 8-15-05 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 5:13 AM **Physician** VICTORIA B. SCHECH 3002 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A SAMARITAN BALTI MORE
Under 1 Year | If Under 24 H HOSPITAL 5000 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 8/28/1928 9. Birthplace (State or Foreign 5. Social Security Number 26-5283 **Funeral** Days Hours Min 1 M 2 X F MARYLAND 212-10-9620 76 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ir Itams 23a or 28e-f show tings must be catilled at 1 Yes 2 No LOCH RAVEN VILLAGE Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21234 8155 GLEN GARY ROAD Pages 1 and 2 should be filed within 72 hours after death neat of Health and Mental Hygiene.

Int. Il tem 27 is marked other than "natural", or Itama 23 array or other traumatic event, if a Medical Eut insurrusal may or other traumatic event, if a Medical Eut insurrusal. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 1 □ Never Married 2 □ Married 21215-0036 1 ☐ Yes 2 ☐ KNo If Yes, Give Year or Dates: Specify: Specify: þ WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SETON HIGH SCHOOL RECEPTIONIST 10TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be THECLA ZAGIZECKA GEORGE BANACHOWSKI ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DRXEL HILL, PA 19026 755 ORMOND AVENUE GREGORY SCHECH/SON 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 8/12/2005 BALTIMORE, MD permit. Page Department of Importent: If any injury or once. PARKWOOD CÉMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses Heather 8521 LOCH RAVEN BLVD. TOWSON, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THYROID MEDULLARY CARCINONA **Physician** METASTATIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): ician/Medical as the attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy jo Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the detached Physi 9 Unknown The law requires that the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Dunknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 2□ No 1☐ Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Matural 5 Pending investigation 1 Tes 2 No М death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8/3/2005 KES 000 ague

State Registrar IZUKANJI

31. Date filed (Month, Day, Year)

LOCH

RAVEN

BLV)

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

SIKAZWE

5601

32. Registrar's Signature

GOOD SAMKRITAN HOSPITAL

BALTIMURE MP

Amend 1 tem 8 per th 8846 8-11-05 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. 2.005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 13:50 PM 2005 /Medical Pearl Frances Spence 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs.
Wonths Days Hours Min. Union Memorial Hospital 8. Date of Birth (Month, Day, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 📆 F Months Director 218-10-9494 17.05Maryland Aug. Usual Residence of Decedent with the Maryland Show 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f shov It e Medical Examinar must be notified at 1√2 Yes 2 No Director Baltimore MD n/a10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3109 Chestnut Ave. 21211 death USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours eiter 0 Dep...ment of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iten any njury or other traumatic event, the Modical Examina. Black, White, etc. ☐Yes 2☐No fYes, Give 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3. Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Daniel F. Buckley Emma T. Kopp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Sousa- Daughter 3149 Crittenton Pl. Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ¥23 Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery Aug. 12, 05 Baltimore City 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypercorbic Luna Disease /Medical to (or as a consequence of): Examiner ohoscolicsis o (or as a consequence of): Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed as the burial-transit and Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9∏ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy 1 ☐ Yes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending within 24 hours after death. To the Funerel Diractor: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the } 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT2438946 (amon, M.)

DHMH 17 Rev 1/2001

State

Registrar

32. gistrar's Signature

UNION MEMORIAL HUSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LATRUMA C. LEMON, M.D. UNION

31. Date filed (Month, Day, Year)

AUG 1 1

			For	State of Man	yland /					-	_			
			State Registrar		_	Cer	tificate of L	Death			Reg. No.	005	2617	<u> 13</u>
н	Physici	an	1. Decedent's Name (First, Middle, Las		-	<	30 00			. Date of De. Month	Day	Year	3. Time of D	м
	/Medic	al	4a. Facility Name (If not institution, give	street and number))(4b. City, Town, or	Location		August		2005 county of Death	5:00	A ^M
п	Examin	er	468 Royal Beach				Pasader					ne Arur	ide1	
	Funeral		5. Social Security Number 6. Se	7. Age (I	n yrs. last b	irthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8 Min.	Date of Bird (Month, Da			place (State or I	Foreign
н	Director		217-14-3283	□ M 2 🗗 F	81	Yrs.	Worth's Day's	Tiodis		9/9/19	23	MD		
	and		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Tov	wn or Loc	ation						10d. Inside City	Limits
	Mary f aho	tor	MD Anne Aru	ndel	Pasade	ena							1 🗀 Yes 2	2 🔀 No
	r 28a	Director	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Cou	ntry?	
	23a c		468 Royal Beac	n Road			21122				U.S.A	٨.		
	tems	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. W	las Decedent of Hi Yes, specify Cuba	ispanic Ori in, Mexicar	gin? (Speci n, Puerto Ri	fy Yes or No can, etc.)	. 14	 Race - Ameri Black, White, 		
3	rs afte	by F	1 ☐ Never Married 2X2Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1	☐Yes 2X No	Specify:			s	Specify: Whi	.te	
9500-61212	iled within 72 hours after death with the Maryland Hygiene. yther than "natural", or llems 23a or 28e-f ahow ant, the Medical Evan armust be mellfod at		15. Decedent's Ed	ucation	168	a. Deced	ent's Usual Occupa	ation			16b. Kind	d of Business/In		
7	thin 7 e.	Completed	(Specify only highest gra	College (1-4or 5+)		life. D	kind of work done of O NOT use retired	during mos f)	t or working					
	be filed wit ital Hygien d other the	Con	12		Ho	omem	aker					Home		
Maryland	9 7 5	Be	17. Father's Name (First, Middle, Last) George Kaline						ie Ka	First, Middle, 1 i n.e.	Maiden S	iumame)		
Š	should be nd Mental marked c	유	19a. Informant's Name/Relationship (7	vpe. Print)	19	b. Mailin	g Address (Street a				er. City or	Town. State. Zii	Code)	
<u>8</u>	and 2 sealth ar m 27 is		Mr. Charles H. S	**			Royal Be							
ē,	item other		20a. Method of Disposition		- Alleria		sition (Name of atory or other plac		Dat			ation - City or To	own, State	
Ē	Pages nent of ant: If it ary or o		to Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	rieniovai irom State			en Mem. H	_ +	8/13/	/2005	Glen	Burnie	, MD	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 Is marked any injury or other traumatic e once.		21. Signa ure of Funeral Service Licen				Name and Address			-		eral Ho		
	40 E E G		HALL		14//		Second A					MD 210		
			23a. P.nt1. E. (er e insease, or compock, or antibillure. List only of immediate Cause (F) al	one cause on each line.	e death. Do	not ente	r the mode or dyin	g, such as	cardiac or i	* A :	rest,		Approximate Interval Betwee Onset and De	∍en ∍ath
	Physician /Medical		disease or condition resulting in death)	a. /VIYOC	ul	3110	11 15)TU	1 CT	101				_
	Examiner			Due to for a set of	Unsequence	200	lic							
7		ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence	of):								
\checkmark	rcuted nd transi	Examin	that initiated events	c										
Ď,	cate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or as a co	onsequence	9 Of):								
98/60	physicate I	dical		d										
ROX	wrequires that the death certif been signed by the attending should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p							23	d. Date of deliv	эгу	
	death e atte	icla	in the past 12 months? 1 Pes 2 No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim			Ectopic pregnancy Other (specify)					Month	Day Ye	ar
J.	at the by th	hys	9 Unknown	9□ Unknown										
_	res th igned be de	by	Part II Other significant conditions of	ontributing to death but n	ot resulting	in the un	derlying cause give	en in Part I	•	23e. Did to		e contribute to t	ne cause of dea pably 4 ⊟Un	
ecords,	requi	eted	Anona	9 1110-							/	V		
Ze Z	The law requires that the to be seen signed by the bage 2 should be detache	Completed								24a. Was autop		24b. Were auto prior to co death?	psy findings av mpletion of cau	ise of
Vital		e Co	25. Was case referred to medical					Of Place	of Dooth (1 ☐ Yes Check only o	2 No	1 🗆 Yes	2□ No	
	Physician: this certific ral director.	0 8	examiner?	Hospital: 1 ☐ Inpatient	2 🗆 ER/O	utpatient	3□ DOA Othe	05		5 DR sic		□Other (Specia	iv)	
וס ר	ding Physi h. After this c funeral dire	T:U	27. Magner of D th 1	28a. Date of Injury (Month, Day Ye	28b.	Time of Injury	28c. Injury Work			d. Discribe i			,,	
000	Attendin death. ctor: Af y the fur	atic	2 Accident investigation			,,		Yes 2	No					
DIVISION	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building, etc. (Specify)	farm, stre	et, factory, office		28	f. Location (S City or Tox		Number or Run	al Route Numbe	<i>∍r</i> ,
	spital or Attendi nours after death. neral Director: A filled in by the t		29a. Certifier 1 Certifying Ph	ysician: To the dest of m	ov knowled	C TOWN	or exercise at this time	nu datu sn	H Harry Sn	A North Andrea	vector addition	NI WARREST	1785.4	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical	(Check only 2 Medical Examone)	iner: On the basis of ex and manner stated	amination a	nd/or inv	estigation, in my or	pinion, dea	th occurred	at the time,	date and p	lace, and due to	the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier	XXX	17		29c. License		27			signed (Month,		
			•	ACK	1		109	5/2	グナ	.01	8	1101	05	
	6		30. Name and address of person who	completed cause of deat	h (Item 23a)	(Type, F	Tala.	Lin	hon	1 (00/0	02)(u -	NDDI	Nol
	0 5	10	31. Date filed (Month, Day, Year)	7 / / / / / / 32.	Signature	101	Titul	1410	iral	7 016		Unice,	111-0/	001
	Sta Registr		AUG 1 1 2	and the second	, de	1	sell!			*				
			MOO I I E	The second		-								

				State of Maryland / D	epartment of Health and M		3
					Certificate of Death	Reg	
		Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
		/Medi	cal	Franklin Vance Snider, Jr.		August 7	, 2005 21:25 ^M
		Exami	ner	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center	4b. City, Town, or Location of Death		4c. County of Death
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		8. Date of Birth	Harford 9. Birthplace (State or Foreign Country)
		Director		228-44-0244 /3	rs. Months Days Hours Min.	(Month, Day, You May 8, 1	932 Virginia
		land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
		Mary	to	Maryland Harford Joppa	1		1 □ Yes 2 XNo
		within 72 hours after death with the Maryland ane. Inan "netural, or lams 23a or 28e-f show than "netural, or lams 12a notified at	Director	10e. Street and Number	10f. Zip Code	10g	Citizen of What Country?
25		s 23a		810 Bradley Road	21085		USA
212	"	fter de ritam	Funeral	11. Marital Status 1 □ Never Married ※ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 1 ▼ 1 Yes 2 □ No	 Was Decedent of Hispanic Origin? (Spe- If Yes, specify Cuban, Mexican, Puerto F 	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
.0	036	al', or	þ	1 □ Never Married	1 ☐ Yes 2X No Specify:		Spacify: White
	21215-0036	72 hc	Completed	15. Decedent's Education 16a. [(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of workin	161	p. Kind of Business/Industry
	121	l within iene. r than '	mp	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		
		filed Hygi ther	Be Co	10 T	ruck Driver 18. Mother's Name		Freight Hauler
	/lar	should be nd Mental marked o	To B	Franklin Vance Snider, Sr.	Edith	Lavonia	Burkett
	Maryland	2 E E E			Mailing Address (Street and Number or Rural		
10		of Health itam 27			Bradley Road, Joppa Disposition (Name of Day		
10	Baltimore,			1 Surial 2 Cremation 3 Removal from State cemetery,	crematory or other place)		: Location - City or Town, State
1	뺥	permit. Page Department of importent: If any injury or		21. Signal of Fueral on License	Hill Mem. Park 8/11/ 22. Name and Address of Facility MC		ltimore, Maryland
O	ä	permi Depa impo any is		Marcott	1317 Cokesbury Road		•
	г			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac or	respiratory arrest,	Interval Between
		Physician	0	Immediate Cause (Final disease or condition resulting in death)	dial Inforction	V	Onset and Death
	-	/Medical Examiner		Due to (or as a consequence of		/	7 /
Z		400	ler	Sequentially list conditions, if any, leading to immediate b. Due t (or as a consequence of	TIC Ca di Ovascula	Clisius	ic Suys
210640	W	xecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter under ying Cause (Disease or injury that initiated events c.	~		3 yrins
40	90	ite be executed ysician and ne burial-transit		resulting in death) Last D e r (or as a consequence of):		
#	68760,	5 × 6	dicai	d			
• •	Box 6	ndir use	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
	œ.	ne death the atte	sicia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
	P.O.	that the died by the detached	Phys	9 Unknown 9 Unknown			
	ds,	signed I	l by	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.		co use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Unknown
1	Sor	w requir been si should	letec	frager voies reciem, ci			
rank	Vital Records,	he lav e has ige 2	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
1,0	ta	sici an: The lav certificate has rector, page 2	0	25. Was case referred to medical	26. Place of Death	1 Yes 2	No 1 ☐ Yes 2 ☐ No
ď	-	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outp.	Other		6 □Other (Specify)
B	n of	ding PI h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Tin 1 ☑ Natural 5 ☐ Pending (Month, Day Year) Inju	ne of 28c. Injury at 28 ury Work?	d. Describe how in	
	Division	Attanding Physician: r death. sctor: After this certific by the funeral director.	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm	M 1 Yes 2 No	26 1 12 124 1	
nid	Di√	after Direct	Certification;	4 Homicide determined 289. Place of Injury - At home, farm building, etc. (Specify)	i, street, factory, office	City or Town, St	and Number or Rural Route Number, ate)
V)		To the Hospital or Attending Physicien: The lawinthin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Check only 2 Medical Examiner: On the basis of examination and/	death occurred at the time, date and place, an	id due to the cause	e(s) and manner as stated.
		To tha H within 24 To tha Fi complete	Medical	one) and manner stated.			
		To with con	2	29b. Signature and title of Contifier	29c. License number	29d.	Date signed (Month, Day, Year)
	7	-11		30. He and address of person who complete cause of death (Item 23a) (Ty	H39022	Mi	Just 7 1005
		47	1	30. a a daddess of person who complete cause of death (Item 23a) (T)	res Carles Mes Files	en 1 111	17
		Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		- vvug · vv	
		Registr	ar	AUG 1 1 2005 Mayer & Ange	as a		

DHMH 17 Rev 1/2001

Snider, Frank

			1 - For State Registrar	State of Ma	ryland		artment tificate			and Me			005	2	6175
	Physic /Medi		1. Decedent's Name (First, Middle, Last	nner							2. Date of De Month	Da			3. Time of Death 5:07 PM
	Examir			street and number) Yaryland 1	ledica	Center	Ba	1tiv	Location o		3	40	County of D	eath	
	Funeral Director		5. Social Security Number 6. Se	7. Age	(In yrs. ia 68	Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Bird (Month, Da May 14,			_	ce (State or Foreign r) nsylvania
	Maryland -f show	tor	10a. State 10b. County Maryland Anne A		10c. City,	Town or Lo	cation	Seve	erna Pa	nrk				100	I. Inside City Limits
	3a or 28e	Funeral Director	10e. Street and Number 297 Riverdale Dr.				10f. Zip	Code	211	46		10g. Ci	tizen of What	Country J.S.A.	
920	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "natural", or items 23s or 28e-f show other treumatic event, it a Medical Example routh by motified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1	Vas Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No lican, etc.)	-	14. Race - A Black, W Specify:	/hite, et	
21215-0036	filed within 72 ho Hygiene. ther then "natura ent, It e Madical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+		16a. Deced (Give life. L	lent's Usua kind of wor OO NOT us	k done d e retired)	tion uring most		g	16b. K	ind of Busine	ss/Indu	•
Maryland 2	should be filed and Mental Hygin is marked other sumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Harold Theod	ore Truninger								l Mar	ie Dague		
	s 1 and 2 sh f Health and item 27 is m other treum		19a. Informant's Name/Relationship (T) Mr. Dale Skinner 20a. Method of Disposition	Husband	20b. Pla		97 Rive	rdale [Or. Sev		Route Number ark, Mary	land 2			
Baltimore,	permit Pages Department of I Importent: If its any injury or o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Sorvice Licens		129-	Вауу	ew Cre	mator d Addres	y s of Facility	у	9/2005		Balti	more	MD
	EGE E E		23a. Part1. Enfer the disease, or compl shock, or heart failure. List only o	ications that caused the cause on each line	ne death.	Do not ente	38	371 OI		nbia P	ke Ellicot		MD 210	A	pproximate hterval Between bet and Death
	/Medical Examiner	_	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a Due to (or as a Due to (or as a										5	days days
), ⁽²	ate be executed hysician and the burial-transit	I Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a	conseque	Pen-	ronit		20040			_			5 days
κ 68760,	ate the	Medica	IF FEMALE:	ENDS			VER	DI	SEAS	Ε					
.O. Box	at the death certific by the attending patached for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal	death 3□	Ectopic pre Other (spe					П	23d. Date of Month	delivery Da	ay Year
ords, P	The law requires that the te has been signed by the has been signed by the hage 2 should be detache	by	Part II. Other significant conditions con	ntributing to death but	not result	ting in the ur	nderlying ca	tuse give	n in Part I.			bacco (to the Probab	cause of death?
of Vital Record	@ LL	Completed	Caronary Arter	y Diseas							24a. Was autop perfo 1 Yes	sy	prior death	to comp	y findings available letion of cause of ☐ No
	ng Phys ter this neral dis	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	dospital: 1 Impatient 28a. Date of Injury (Month, Day)	2	R/Outpatien 28b. Time of Injury		A Othe Bc. Injury Work	r: 4□ Nur	rsing Hom 28	(Check only o e 5 ☐ Resid 3d. Describe h	lence		pecify)	
Division	tel or Attendii rs after death. el Director: Al ed in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At hom (Specify)	ne, farm, stre	et, factory,	office		28	3f. Location (S City or Tox	itreet an m, State	d Number or	Rural F	oute Number.
	To the Hospitel or, within 24 hours attent To the Funerel Directional Completely filled in the Funerel Direction of the F	edical	29a. Certifier Certifying Phy. (Check only one)	sician: To the best of ner: On the basis of e and manner state	xaminatio	ledge, death on and/or inv	occurred a estigation,	it the time in my op	e, date and inion, deat	d place, ar h occurred	nd due to the o	ause(s) date and	and manner place, and o	as state lue to th	ed. e cause(s)
)	To the P within 24 To the R complete	Σ	29b. Signature and title of certifier	elli ME)			License	number 58 (0		29d. Da	te signed (Mo	7	y, Year)
	4		30. Name and address of person who co	ompleted cause of dea	th (Item 2	SOUTH	Print)			STEE	T BA	LTIM	DRE I	MD	2/201
	Sta Registr	1	31. Date filed (Month, Day, Year) AUG 1 1 2005	22. Registrar	s Signatu		w								

		•	For State Registrar	State of Marylar		artment of F			giene 109. N2 0 0 5	26176
	Physicia	an	Decedent's Name (First, Middle, Last)	Wessel Asa	Tarun	Tr		2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give s		rar un,		r Location of Death	August	9 2005 4c. County of Deat	4:43 P. M
	Examin	er	1179 Annis Squa		:	Pas	adena		Anne A	
	Funeral Director		5. Social Security Number 6. Sex 212 22 1348	7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day April 2		nplace (State or Foreign untry) cvland
	ס		Usual Residence of Decedent 10a, State 10b, County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Maryla -f sho	to	Maryland Anne Aru		Pasader					1 ☐ Yes 2 🛣 No
	or 28a	Funeral Director	10e. Street and Number		10	10f, Zip Code			10g. Citizen of What Co	untry?
	sath w	eral	1179 Annis Squa	m Harbor 12. Was Decedent Ever in U	15 13 1		122 lispanic Origin? (Sa	pecify Yes or No-	U.S.	rican Indian.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: WWI		f Yes, specify Cubi	Specify:	Rican, etc.)	Black, White Specify: Wh	e, etc.
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade		(Giva	dent's Usual Occup kind of work done	durina most of wor	king	16b. Kind of Business/	ndustry
21215-0036	d within giene. rr than	Completed	Elementary/Secondary (0-12) 5th	College (1-4or 5+)		DO NOT use retired ck Driver			Trucking C	ompany
Maryland	uld be filed fental Hyg rked othe ilc event,	To Be C	17. Father's Name (First, Middle, Last) Wessel	A. Tarun, S	r.			ne (First, Middle, en Laura	Maiden Sumame) Hoffman	
lary	2 should and he ls mains	()	19a. Informant's Name/Relationship (Type			-			r, City or Town, State, Z	
e,	1 and Health em 27		JoAnn Tarun / w	20b.	Place of Dispo	sition (Name of	quam Harb	Date Pas	sadena, Mar	
DOE	Pages nent of nt: If it		1 XBurial 2 ☐ Cremation 3 ☐R 14 ☐ Donation 5 ☐ Other (Specify)			veteran		2/2005	Crownsville	e, Maryland
Baltimore,	permit. Departmine of the permit of the perm		21. Signature of Funeral Service License	musuul		Name and Address 001 Ritc			eral Servicimore, Mar	
	湖. 唯		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the dea e cause on each line.	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical	9	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	of U	ung				
	Examiner		Sequentially list conditions		quence or).	ν				
1	pe iis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):					
<u></u>	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
8760,	eath certificate be executed attending physician and for use as the burial-transit	dlcal								
Box 6	death certific e attending p id for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr					23d. Date of deli	very
P.O. Bo	0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)	y		Month	Day Year
	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions con	stributing to death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to €s 2 □ No 3 □ Pr	the cause of death?
Vital Records,	0 5 0	Completed						24a. Was a autop perfor	sy prior to o	topsy findings available completion of cause of
tal	T ate	a	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		2 No
	S S	To B	examiner? 1 Yes 2 No	lospital: 1 [Inpatient 2 [] ER/Outpatier	IL SLI DOA		ome 5 Resid	ence 6 □Other (Spec	cify)
ion of	inding Phath. rr: After the		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ry at rk? Yes 2 □ No	28d. Describe h	ow injury occurred	
Division	al or Atte s after de il Directo d in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		reet, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	iral Route Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edical (29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Examination	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	, and due to the o	ause(s) and manner as date and place, and due	stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	14		29c. Licens	se number		29d. Date signed (Monti	
	(12	mulated access of the state of	- 99-1 /*		, , , ,		Aug 10, 2	
	5X		30. Name and address of person who co Dr. Basant Kand				hway Suit	e 201 G1	en Burnie,	MD 21061
	Sta Registr		31. Date filed (Month, Day, Year) ALIG 1 1 2005	39. Registrar's Sign	nature	ريك				

			State of Maryland / Department of Health and Mental Hygiene 1- Steta Reg. No. 2 1 1 5 2									201	77	
	Physic		1. Decedent's Name (First, Midd		Roger Nelson Trone					2. Date of Death Month Day Year August 8, 2005			3. Time of Death 9:50 a. M	
	/Medi Exami		4a. Facility Name (If not institution	n, give street and num	reet and number) 4b. City, Town, or Location of Death							y of Death		
	Funeral Director		5. Social Security Number 219-44-9930		7. Age (In yrs. last birthday 60 Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. 8 Min.	B. Date of Birth (Month, Day,		9. Birth	pplace (State or I intry) Maryland	Foreigr
	28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland	Howard	10c. City, Town or L	ocation	CI	arksville			10d. Inside			Limits 2 No
	ath with th 23a or 28 ust be no	rai Dire	10e. Street and Number 5911 Gentle Call		10f. Zip Code 21029			11	10g. Citizen of What Country? U.S.A.		•			
980	within 72 hours after death with the Maryland ene. than 'natural', or Itams 23a or 28a-1 show to Medical Eracinat must be notified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 ▼ Divorced	ried Armed Ford	Vistnam	Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto Ri	ify Yes or No- ican, etc.)		ck, White	ican Indian, , etc. White	
21215-0036	I within 72 ho iene. r than "natur i're Medical	ompleted		t's Education st grade completed) College (1-	16a. Dece (Give	dent's Usua kind of wor DO NOT us	k done d e retired,	urina most		7	16b. Kind of E		ndustry mployed	
Maryland	. I and 2 should be filed Health and Mental Hygi Iam 27 is marked othar Isther traumatic avant, I	To Be C		Last) es LeRoy Trone				18. Mother	r's Name (ce D. We	st		
Σ		1 1	Ms. Shannon Tr 20a. Method of Disposition	one Dau	ghter 20b. Place of Dispo	5911 Ge	ntle C	all Clark		Route Number, Maryland 2 te 2				
	permit. Pages Department of the Important: If its any injury or of one one of the one of		1 Burial 2 Cremation 4 Donation 5 Other (S	pecify)	Bay	view Cre 2. Name and	mator d Addres	y	/	9/2005 P. A	E	Baltimo	re, MD	_
	h. After this certifica funeral director,	dicai Examiner	23a. Part1. Enter the disease of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to (or	r as a consequence of):	h.							Interval Betwee Onset and Dea One y ea	ath
DOX O		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birt	nt at time of death 5	Ectopic pre						te of delive	ery Day Yea	ar
Lj		by	Part II. Other significant condition	cant conditions contributing to death but not resulting in the underlying cause given in Part I. 239. Did toba							acco use contribute to the cause of death? S 2 No 3 Probably 4 Unknown			
I Hec		Completed		-						24a. Was an autopsy perform	ed?	Were auto prior to con death?	psy findings ava mpletion of caus 2/17 No	ulable se of
DIVISION OF VIR		Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Actident investig 3 Suicide 6 Could in	ation	Injury Day Year) 28b. Time of Injury	28 M	C. Injury: Work?	4 □ Nurs	sing Home 28d	Check only one 5 X Residen d. Describe how	ce 6 □Oth rinjury occurr	ed		
	within 24 hours after death To tha Funaral Director: completely filled in by the f		4 Homicide determ 29a. Certifier 1 Certifyin	ned 289. Place of building	Injury - At home, farm, str , etc. (Specify) est of my knowledge, death	Occurred a	t the time	date and	Since and	City or Town,	State)		I Route Number,	;
Tothollo	within 24 h To tha Fu	Medicai	(Check only one) 2 Medicel 29b. Signature and title of certifier	xaminar: On the basi and manner	s of examination and/or in	restigation, i	n my opi	nion, death	occurred	at the time, dat	e and place, a	and due to	the cause(s)	
	6		30. Name and address of person	who completed cause	of death (Item 23a) (Type,	Print)		239	•		ugust	8,	2005	
	Sta Registr		Mark Levis 31. Date filed (Month, Day, Year)	1650 (38 Reg	orleans Streistrar's Signature	et B	altiv	nore	Mary	land				

PAUL TALLEY 05-05334 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	Maryland		artment of H		and Me		000) (~	06170
			1 - State Registrar Certificate of Death Reg. N								15	3. Time of Death	
80	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day AUGUST 7,								Year O5	7:20P. M	
1	/Medic Examin		4h City Town and continue of Depth							4c. County of		7.201.	
	Examin	eı	JOHNS HOPKINS HO	•			BALTIMO	ORE					
	Funeral Director		5. Social Security Number 215-25-1875	6. Sex 1 M 2□F	Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 4 / 8	Year) 87	9. Birthp Cour	place (State or Foreign http:)
147	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or L	ocation						10d. fnside City Limits
	aryla shov	ŏ	MD 100. County		BA		9						1 Yes 2 □ No
	286-1	rect	10e. Street and Number				10f. Zip Code			10	0g. Citizen of W	/hat Cour	ntry?
	3a or	0	2623 300	ONE ST.			21	218			4	5	
936	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is merked other then "natural", or Items 23a or 28e-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 15 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Ford	□ No		Was Decedent of HIFYes, specify Cub	an, Mexican	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)	Black	k, White,	ean Indian, etc.
5-0036	72 hou	ted	15. Decedent' (Specify only highest			16a. Dece	dent's Usual Occup	oation	t of workin	na l	16b. Kind of Bu	siness/In	dustry
2121	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-		life.	kind of work done DO NOT use retire				Construction		
121	filed within Hygiene.		17. Father's Name (First, Middle, L	act)			TEXPE		ar's Name	(First, Middle, N	Maiden Sumame	e)	
Maryland	2 should be fand Mental Hamarked of	To Be	CLif		nilno			3	EVE	-Rly	LEU	UIS	
	1 and 2 sho Health and I em 27 is m		Gloria Bw				ng Address (Street						
Baltimore,	Pages 1 and of He int: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		сел	netery, cre ETR	osition (Name of matory or other pla	TORY		10.70	ACT-MOR	E, M	D.
Balti	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service L	icensee CFSP.C	PC	2	2. Name and Addre	ess/f Facilit	MON	rellips 1806 ST	Funer. BACT	MOA	ONE E, MD ZIZIT
b- 15	î j o		23a. Part1. Enter the disease, or shock, or heart failure. List of	only one cause on ea	ch line.			_			est,		Approximate Interval Between
4.	Physician		fmmediate Cause (Final disease or condition	(sunsh	ot 1	Nounds	(2)	of t	tead			Onset and Death
31	/Medical Examiner		resulting in death)		r as a conseque								
- 1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (o	r as a conseque	nce of):							
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	r as a conseque	nce of):							
8760,	sician buria				, , ,								
687	flicate g phys	edlc		d									
O. Box	law requires that the death certificate be executed as been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetal d nt at time of dea	eath 3[⊒Ectopic pregnanc □ Other (specify) _	ey .			23d. Date Mor		ery Day Year
<u>α</u>	that the de and by the a detached t	by Ph	Part II. Other significant condition	ns contributing to dea	th but not result	ing in the ι	inderlying cause gr	ven in Part f		23e. Did tob	pacco use contr	bute to f	the cause of death?
rds	w requires that s been signed t should be det	ed b								1 □ Y€	s 2 1 No	3 🗌 Prol	bably 4 □Unknown
Records,	law re as bee 2 sho	Completed								24a. Was a autops	n 24b. V	Vere auto	opsy findings available ompletion of cause of
Ě	The ate h page	E O								✓ perforr	ned? d	death?	2□ No
of Vital	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital					of Death	(Check only on	(8)		
of	Physi this o	. To	1X Yes 2 No 27. Manner of Death			R/Outpatie	nt 3LI DOA			ne 5 Reside			fy)
	After After	tlon	1 □ Natural 5 □ Pending	9 - 1 - 1	(Month, Day Year) Injury Work?					28d. Describe how injury occurred			+
Division	Attending ir death. ector: After by the fune	Illca	3 ☐ Suicide 6 ☐ Could n	not be 28e. Pface	of Injury - At hom		reet, factory, office		2	28f. Location (St	treet and Number	er or Rui	al Route Number,
ă	s after	Certification:	4 Homicide	bullain	g, etc. (Specify)	Lot					121 1/1 800	KLI	30HLS+
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (g Physician: To the t Examiner: On the ba and mann	sis of examination								
	Fo the	Me	29b. Signature and title of certifier			I L	29c. Licen	se number		2	9d. Date signed	J (Month	Day, Year)
	/) (land	e Haro	an IN	d	0.C	.M.E.		A	UGUST 8	, 20	05
	7		30. Name and address of person	who completed cause	of death (Item 2	23a) (Type		CITIE TO		TUTNODE	MADS/T A	NID O	1 201
	Sta	ite.	31. Date filed (Month, Day, Year)	32. R	gistrar's Signatu	re		STREE	LI BA	LTIMORE	MAKYLA	ND 4	1401
	Regist		AUG 1 1	2005	seven h	4.	back						

		State of Maryland / Dep	artment of Health and M	•	gible.						
	1 - State Registrar	Ce	rtificate of Death	Reg. No 2	005 26179						
Physician	Decedent's Name (First, Middle, Last)			Date of Death Month Day	3. Time of Death						
/Medical	June Clark 4a. Facility Name (If not institution, give si	Weeks	4b. City, Town, or Location of Death	August 8, 20							
Examiner	Lorien Nursing & Re				nty of Death Cford						
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)						
Director	117-16-0567 Usual Residence of Decedent	M 20 F 83 Yrs.	Months Days Hours Min.	June 15, 192	2 New York						
yland	10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits						
Baltimore, Maryland 21215-0036 Baltimore, Maryland 21215-0036 Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Important: If time 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examirer must be notified at once. To Be Completed by Funeral Director	Maryland Harford	Bel Air			1X Yes 2 ☐ No						
3a or it ben	27 Idlewild Street		10f. Zip Code 21014		of What Country?						
ms 2		2. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	USA ocify Yes or No- 14. R	ace - American Indian,						
after or Ite	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	Rican, etc.) B	lack, White, etc.						
21215-0036 21215-0036 d within 72 hours after giener, or the rethan "naturer, or the rithan "naturer, or the Completed by Fur	3 Widowed 4 Divorced 15. Decedent's Education	Year or Dates:			White						
121215-00 ed within 72 hou yejenen "nature ner than "nature it, in a Medical Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) (Giv life.	edent's Usual Occupation a kind of work done during most of worki DO NOT use retired)	ng 16b. Kind of	Business/Industry						
Som of with some strange of with some strange of the sound strange of th	Elementary/Secondary (0-12)	College (1-4or 5+) 4 H	omemaker	Own	Home						
ind 2 be filed tal Hygie d other; avent, in	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maiden Sum:							
aryla should the should the smarked the smarked the smarked the smarked the should the s	Dr. Ross Armst				King						
Maryland Maryland d 2 should be file thand Montally 77 is marked oth traumatic avent To Be C	19a. Informant's Name/Relationship (Typ Mary Ranneberger -		ing Address <i>(Street and Number or Rura</i> 5 Vail Road, Bel A								
Neeks	20a. Method of Disposition				n - City or Town, State						
Leek altimore, altimore, altimore, law, pages 1 a portant: If tiem y injury or othe	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Domation 5 ☑ Other (Specify)	movar nom otate	Service Corp. 8/10	/05 Towson	n, Maryland						
Balti Bernit. Departir Importa eny inju	21. Signature of Funeral Service Licensee			Comas Funera							
B 8 8 8 8 8	1 Mars		1317 Cokesbury Road	l, Abingdon, I							
			ter the mode of dying, such as cardiac o		Approximate Interval Between Onset and Death						
Physician / /Medical	disease or condition resulting in death) a. ARTERIO SCIEROTIC CARDIOVAS CILLAR DISERSE										
Examiner		Due to (or as a consequence of):									
Jer Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):									
executed in and ial-transit Examiner	that initiated events										
	resulting in death) Last	Due to (or as a consequence of):									
3876(cate be physicia the but	d.										
Box 68 death certifica e attending ph of for use as th	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy		234 [Date of delivery						
Geath death death	in the past 12 months?	4☐Pregnant at time of death 5[☐Ectopic pregnancy ☐ Other (specify)		Month Day Year						
is, P.O. Box 68 es that the death certifica igned by the attending ph be detached for use as the by Physiclan/Med	9 🗌 Unknown	9□ Unknown									
ords, P.O requires that the nean signed by th hould be detache	Part II. Other significant conditions control CEREBROVASC	ibuting to death but not resulting in the t			ntribute to the cause of death? 3 Probably 4 Onknown						
Q > D 0	HYPERTENSION			24a. Was an 24b	. Were autopsy findings available						
f Vital Recyysician: The lavis certificate has director, page 2	EMPHYSEM A			autopsy performed?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No						
/ita	25. Was case referred to medical	2.1	26. Place of Death								
of Vita Physician: this certific ral director.	1 ☐ Yes 2 ☑ No ☐ Ho 27. Manner of Death	spital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury 28b. Time of		ne 5 Residence 6 Of							
on on ding F. After funeri	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occu	urred						
Division c tal or Attending P is after death. al Diractor: After t ed in by the funera Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st		8f. Location (Street and Num	nber or Rural Route Number,						
Di ttal or ris afte ral Dir led in		building, etc. (Specify)		City or Town, State)							
Division or To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cien: To the best of my knowledge, deat r: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the cause(s) and m d at the time, date and place	nanner as stated. , and due to the cause(s)						
To the within Volume to the complex	29b. Signature and title of certifier		29c. License number		ed (Month, Day, Year)						
	1 Mtshy	antar MD	D 25027	Lugus	78 2005						
12	30. Name and address of person who co	pleted cause of death (Item 23a) (Type,		F1 40	UD SIA						
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	LIFE OF LIVE CO	- TIN	1- 41014						
Registrar	auc 1 1 700	10 Dealers St.	rock								

		•	1 - For Sta	ate of Maryland		artment of H			jiene •9. N2 0 0	5 26180		
H	Physicia	an	1. Decedent's Name (First, Middle, Last) Mildred (NMN) Young					2. Date of Dea Month	th Day	3. Time of Death		
	/Medic Examin	cal	4a. Facility Name (If not institution, give street	· ·		4b. City, Town, or			4c. County of Death			
			1611 Van Bibber Road 5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthdav)	Edgewoo	OCL If Under 24	Hrs. 8. Date of Birth		Harford 9. Birthplace (State or Foreign		
	Funeral Director		225-38-9324 ¹□м ²		Yrs.	Months Days	Hours	Min. 8. Date of Birth (Month, Day)	1931	9. Birthplace (State or Foreign Country) West Virginia		
death with the Maryland	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo					10d. Inside City Limits		
	the Mar	ector	Maryland Harford 10e. Street and Number		Edgew	10f. Zip Code			log. Citizen of W	1 ☐ Yes 2 🛣 No		
	th with	al Dir	1611 Van Bibber Road	3		2104			USA			
0	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hyglene 1 them 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, Ita Modical Erocinier must be notified at	by Funeral Director	1 Never Married 27 Married	as Decedent Ever in U.S med Forces? □Yes 2⊠No				? (Specify Yes or No- Puerto Rican, etc.)	Black	- American Indian, , White, etc.		
500	filed within 72 hours after Hygiene. other than "natural", or ite ant, I'm Medical Exantina	ed by	3 ☐ Widowed 4 ☐ Divorced	Yes, Give ear or Dates:		1 ☐ Yes 2½ No ————————————————————————————————————	Specify:		Specify:	White		
ים בי	thin 72 e. an "nat	Completed	(Specify only highest grade com		(Give	kind of work done DO NOT use retired	durina most of	f working				
מעו	filed with Hygiene other thai		12 17. Father's Name (First, Middle, Last)		Hom	emaker	18. Mother's	Name (First, Middle,	Own Ho	· · · · · · · · · · · · · · · · · · ·		
угапа	2 should be 1 and Mental I is marked or raumatic eve	To Be	Leonard (UNK) Ray					cie (UNK) V				
	nd 2 she Ilth and 27 is m r traum		19a. Informant's Name/Relationship (<i>Type, P</i> Carl Young/Husband	rint)				ad, Edgewoo		State, Zîp Code) 21040		
je,	ges 1 and 2 of Health if Item 27 i		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Remov	al from State	emetery, crei	sition (Name of matory or other place		Date		City or Town, State		
Saltimor	permit. Pages of Department of Himportant; if Neany injury or ot once.		* 4 □ Donation 5 □ Other (Specify) 21. Sign ture of Funeral Service Licensee	Hol		1 Mem. Pa			Baltimo	re, MD		
ă	Depar Impo any ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between the complex of the death of									
			Immediate Cause (Final	ns that caused the death use in pach line:		er the mode of dyir	ng, such as ca	rdiac or respiratory an	est,	Approximate Interval Between Onset and Death		
	Pnysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ		inale.	D	1 7		Jews 10		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ive Vuluncy Viscase 10 ye								
4	be executed ician and burial-transit	Examin	Cause, Chief or Indigning Cause (Disease of injury that initiated events currently last Due to (or as a consequence of):									
3/6C,	ate be executed hysician and the burial-transit	ical E										
ox ox	death certificate attending phys	P	IF FEMALE: 23c. If	yes, outcome of pregna	ncy				23d Date	of delivery		
). DO	ath or u	Physician/M	230. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Helpon at time of death 5 Other (specify)						Mon			
ب آ	uires that the des signed by the a Id be detached fo		9 ☐ Unknown Part /I. Other significant conditions contribut		ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	tobacco use contribute to the cause of death?			
cords	w requires that been signed by should be deta	ted by	Hypertesion					128	1 Yes 2 No 3 Probab			
Zec Zec	e law has b	ompleted	71						24a. Was an autopsy performed?			
<u>E</u>	ysician: Th	Be Co	25. Was case referred to medical examiner?					1 ☐ Yes Death (Check only or		□Yes 2□No		
<u> </u>	Phys r this ral dii	2	1 ☐ Yes 2 ☐ No Hospit	al: 1 ☐ Inpatient 2 ☐ a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o		4 Iquisi		ome 5 esidence 6 Other (Specify) 28d. Describe how injury occurred			
Vision	Attending for death. ector: After by the funer	catlor	2 Accident investigation		Injury	M 1 🗆	rk? Yes 2 □ No					
=	i Ditto	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28	 e. Place of Injury - At ho building, etc. (Specify 	me, farm, sti	reet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,		
	urs ille	edical C	29a. Certifier 1 Certifying Physician (Check only one) 1 Medical Examiner: (To the best of my known the basis of examinate and manner stated.	wledge, deat tion and/or in	h occurred at the til vestigation, in my o	me, date and popinion, death	place, and due to the occurred at the time, o	cause(s) and mar date and place, a	ner as stated. nd due to the cause(s)		
	To the Hos within 24 ho To the Fun completely f	Med	29b. Signature and problem of the			29c. Licens	se number		29d. Date signed	(Month, Day, Year)		
	1		30 Name and address of gerson who comple	E Po FACE ted cause of death (Item	1 23a) (Typa	Print)	402	2 1	tryust	7 2005		
	2		Veten / spesti Do	1308 Busne	55 (be	fully	Klyer	ved Ald	1040			
	Sta Regista		31. Date filed (Month, Day, Year) AUG 1 1 2005	32. Registrar's Signa	Speed	W						

			Please	Type or Pri				-	-	ble.			
			1 - State	State of M	aryland / Dep	artment of <i>rtificate of</i>			-	~ ==	0		
			Registrar 1. Decedent's Name (First, Middle, Li	ast)		runcate of	Deam	2. Date of Dea	th	15	25 8		
	Physici		MANCHESTER COLLEY					Month	Day	Year	3. Talle of Death		
	/Medio Examir		4a. Facility Name (If not institution, gi			4b. City, Town,	or Location of D	JULY Death	26, 20 4c. County		10:23 P [™]		
1	LAdiiii	ici	Salisbury Nursi		ab Center			sbury, Md.		omico			
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday	If Under 1 Year Months Days	If Under 24	Hrs. 8 Date of Birth		9. Birthp	lace (State or Foreign		
	Director		218-26-8740	11∑M 2□F	76 Yrs.			Min. (Month, Day 04-05-1	929	ALBA	NY, NY		
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10	0d. Inside City Limits		
	Mary F sh	ţo	MD WICON	1ICO	SALISBUE	RY			1 □ Yes				
	h the	Funeral Director	10e. Street and Number	-		10f. Zip Code			0g. Citizen of V	try?			
	th wit	aD	904 MT. HERMON RO	OAD		2	1804		US	SA			
	tems tems	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin' oan, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		an Indian,			
36	s afte	y Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐,Yes 2 ☐ i If Yes, Give Year or Dates:	No 1948- 1952	1 □ Yes 2√□ No				Black, White, etc. Specify: WHITE			
8	tural	ed b	15. Decedent's E			dent's Usual Occu	nation	1	16b. Kind of Bu				
21215-0036	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or Items 23a or 28e-f show int, Itte Misdical Examinar must be neitified at	Completed by	(Specify only highest gi	ade completed) College (1-4or 5	(Give	kind of work done DO NOT use retin	during most of	working	TOD. THING OF DE	2011/00/04	iddi.y		
	should be filed withir nd Mental Hygiene. markad othar than imatic avant, IIte M.	Com	12			MECHANI	C		AUTOMOE	BILE (COMPANY		
pu	be file	Be	17. Father's Name (First, Middle, Las	1)			18. Mother's	Name (First, Middle,					
₹	should ind Men s marka umatic	2	GEORGE BOWIE					DA SMITH					
Maryland	2 0 0 0		19a. Informant's Name/Relationship		r Rural Route Number								
	1 and Health Iam 27 other tr		AUDREY HOOK - PER 20a. Method of Disposition	SUNAL REP.	20b. Place of Disp	osition (Name of		SALISBURY Date					
ē	Pages nent of h int: If its ury or of		1 ☐ Burial 2 ☐ Cremation 3 [14 ☐ Donation 5 ☐ Other (Special			matory or other pla	, I	Date 200. Location - City or Town, State 07-28-2005 DELMAR, DELAWARE					
Baltimore,	7 5 5 5		21. Signature of Funeral Service Lice					07-28-2005 DELMAR, DELAWARE BOUNDS FUNERAL HOME, INC.					
ä	Depared Important in suny irrespondent	. 3	11/1/1550 /k	in Here				REET, SALIS					
	561		23a. Part. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each li							Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	· dun	, Con	3				n	Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as	consequence of):								
	LXammer	er	Sequentially list conditions,	b	a a reactive and								
	ocuted nd transit	amlne	cause. Enter Underlying Cause (Disease or injury	D03 10 (01 06	a consequence of):								
		Exar	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):								
68760,	e be e /siciar			. d.									
89	The law requires that the death certificate be exite has been signed by the attending physician a page 2 should be detached for use as the burial	Physician/Medical											
Вох	death certifica attending ph d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnanc	ev.		1	e of deliver	,		
	e dea the at	slcl	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐ Unknown		Other (specify)	•		Moi	nth	Day Year		
P.0	that the de led by the a detached t		9 ☐ Unknown Part II. Other significant conditions	contributing to death b	ut not rogulting in the	and a bridge a source as	in Don't	22a Did tal		dhuta ta th	n acuse of death?		
ds,	signe signe	t by	Tatti. Other signmeant conditions	s 2 🗆 No		abiy 4 @Onknown							
Records,	w requir been si should	Completed											
Rec	The lav	ldm		y p	vere autop rior to con leath?	sy findings available apletion of cause of							
Vital			25. Was case referred to medical								2 No		
<u>=</u>	Physicien: this certific al director,	OB	examiner? Hospital: 1 Inputient 2 FR/Outputient 3 DOA Other: 4 Austrian Home 5 Residence								1		
J Of		n: T	The state of the s								/		
Division	ttendin death. ctor: Aft / the fur	Certification;	2 Accident investigation		200. Describe now injury occurred								
i	I or Attenater deat Director: I in by the	tific	3 Suicide 6 Could not to determined		ury - At home, farm, st	reet, factory, office		28f. Location (St City or Town		er or Rural	Route Number,		
0	ral Di												
	Hosp 24 hot Fune felly fill	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Day Year)									ited. the cause(s)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Med	one) 29b. Signature and title of certifier	and manner sta	ned.								
	7 × 7 0		· M	4				3	7/27	(S))		
•	X	- 9	30. Name and address of person who										

Registrar

State

WILLIAM ROBINS, M.D. 200 CIVIC AVE.,

31. Date filed (Month, Day, Year)

JUL 2 8 2005

32. Resistrar's Signature

DHMH 17 Rev 1/2001

Registrar

2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year JULY **Physician** 2005 DORALEE VIRGINIA BOWMAN 19 1:00 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3501 MURKLE ROAD WESTMINSTER CARROLL 8. Date of Birth (Month, Day, Year) SEPT. 04,1925 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 💢 F MARYLAND 220-16-0735 79 Director Usuel Residence of Decedent 10d. Inside City Limits filed withIn 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State ir than "naturel", or items 23a or 28a-f show the Medical Examinar inust be notified at 1 Yes 2 XX WESTMINSTER CARROLL MARYLAND Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21158 UNITED STATES 3501 MURKLE ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 赵② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XXIo Specify: Baltimore, Maryland 21215-0036 WHITE 3 ♥Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PHOTOGRAPHY PHOTOGRAPHER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be Mental PAULINE AGNES COE permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Is marked any injury or other treumatic events. HARRY KEMP CRUMBACKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2522 LITTLESTOWN PIKE, WESTMINSTER, MD 21158 DREU T. BOWMAN/SON 20b. Place of Disposition (Name of cametery crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MEADOW BRANCH CEMETERY 7/22/2005 WESTMINSTER, MD 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME,
91 WILLIS ST. WESTMINSTER, MD 21. Signature of Funeral Service Licensee P.A. W01191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm late Cause (Final disease or condition resulting in death) our **Physician** /Medical Due to (4 as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed use as the burial-transil Merusder that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9□ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, 1 Yes 2 Ho 3 Probably 4 Unknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 1 ☐ Yes 2 → No 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined filled in by 4 | Homicide ō within 24 hours a

To the Funerel C

completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MJL 2544 15 30. Name of address of person who completed cause of death (Item 23a) (Type, Print) JOHN'W. MIDDLETON M.D. 688C POOLE ROAD, WESTMINSTER, MD 21157 32. Registar's Signature 31. Date filed (Month, Day, Year) State Glown & Sporte Registrar

			1- For State of Maryland / Dep. Registrar Ce	artment of Health and M rtificate of Death	lental Hygier								
ı	Physic	ian	Decedent's Name (First, Middle, Last) Ralph Thomas Blacksten		2. Date of Death Month July	20 2005 4:15A м							
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4949 Middleburg Rd.	4b. City, Town, or Location of Death Taneytown		4c. County of Death Carroll							
	Funeral Director		5. Social Security Number 212-32-4373 6. Sex 18 M 2 F 85 Yrs.	<u> </u>	8. Date of Birth (Month, Day, Ye, July 1, 1	9. Birthplace (State or Foreign							
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland Carroll Uni	ion Bridge		10d. Inside City Limits 1 □ Yes 2 🔥 No							
	with the a or 28	Director	10e. Street and Number 427 Clear Ridge Rd.	10f. Zip Code	10g. (10g. Citizen of What Country?							
920	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or tlems 23a or 28a-f show ont, the Medical Exeminer must be multified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	21791 Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	U.S.A. 17 (Specify Yes or No- Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White								
Maryland 21215-0036	be filed within 72 ho ital Hygiene id other than "netur event, Ire Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cust	ng	Kind of Business/Industry								
yland	e d it b	To Be	17. Father's Name (First, Middle, Last) Ernest L. Blacksten		(First, Middle, Maide lla M. Bar	,							
, Mar	s 1 and 2 should f Health and Men item 27 Is marke other traumetic			ng Address (Street and Number or Rura Sherman Dr. Get	l Route Number, City ttysburg,								
Baltimore,	permit. Pages 1 a Department of He Important: If item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	matory or other place)		Location - City or Town, State Linwood, MD							
Balt	permit. Departi Import any inj		atharine C, worlder		ew Windsor	ral Home , MD 21776							
8760,	death certificate be executed Water Manager M	dical Examiner	23a. Part1. Enter the disease, or complications that cluser the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	bledder	CAA	Approximate Interval Batween Onset and Death							
.O. Box 6	death certif e attending d for use as	Physician/Med		Tectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year							
<u>α</u>	es ngi pe	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		use contribute to the cause of death?							
Vital Records,	The law ate has b page 2 si	e Completed	25. Was case referred to medical	24a. Was an autopsy performed? 1 Yes 2 N									
ō	ling Ph	Certification; To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined Examiner? Hospital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, streething building, etc. (Specify)	6 Mother (Specify) ASST LIVING ury occurred and Number or Rural Route Number, te)									
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invand manner stated.	restigation, in my opinion, death occurre	nd due to the cause/	s) and manner as elected							
ı	WIL	×	29b. Signature and title of certifier 30. Name d address of person of completed cause of death (Item 23a) (Type is	29c. License number DB5392	29d D	ate signed (Month, Day, Year) - 21 - 0 5							
	5 Sta	te	30. Name d address of person o completed cause of death (Item 23a) (Type, Print) Flavio Knuter mb 5555 xut Cauter Street Wet Minister, Mb 21157 31. Date filled (Month, Day, Year) 32. Registrar's Signature										
	Registr		JUL 2 5 2005 Segue &	filed (Month, Day, Year) 32. Registrar's Signature									

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** Year 4.55 PM Joyce M. Blickenstaff KUGI 2005 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Julia Manor Health Care Center Hagerstown Washington 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Days 10M AFF 218-24-9094 Yrs. 76 Director Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours aftar death with the Maryland Department of Heelth end Mantal Hyglene. Important: If Item 27 is marked other than "natures", or Items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "naturel", or items 23a or 28s-f sho or other traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 11922 Peacock Trail 21742 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 ☐ No If Yes, Give Yeer or Dates: 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: White Be Completed by 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Administrator Telephone Co. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Victor P. Clark Mary May Hawbaker 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence Clark/Nephew 2881 Sipes Mill Rd Warfordsburg, PA 17267 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 8-8-05 Hagerstown MD Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FecilityRest Haven Funeral Chapel 21. Signature of Funeral Service Licenses 1601 Pennsylvania Ave Hagerstown MD 21742 23a. Pert1. Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Division of Vital Records, P.O. Box 68760, Cause (Disease or injurthat initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ Completed 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy performed? After this certificeta 1 🗆 Yes 2 12 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Piece of Death (Check only one) Hospital: 1 Yes 2 No 2 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Menne of Death 28e. Date of Injury (Month, Dey Year) Medical Certification: 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation within 24 hours aftar death.

To the Funerel Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier (Check o. one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) TOURSTRURG PR HAGERSTOUN MD21-742 2 SEDDIRUT SHALLAB 31. Dete filed (Month, Day, Year) 32/Registrer's Signature State Registrar 0 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Yea/ **Physician** Edward Leroy BAKER 1, 12:41 p.M 2005 August /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Beverly Health Care Hagerstown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□ F 219-05-2783 Yrs. 87 Director Oct. 3,1917 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 1X Yes 2 □ No Director Florida Indian River Sebastian 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1702 Sunrise Lane 32958 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No white Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, The Medica. Elementary/Secondary (0-12) College (1-4or 5+) engineer aircraft manufacture 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samuel Evers Baker Florence Elizabeth Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Smith - niece 17008 Hillsdale Ct., #90, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/4/05 4 □ Donation 5 □ Other (Specify) Fountainhead Mem. Park Palm Bay, Florida 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryalnd 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Altrero sclout 5 years **Physician** ardio voscular /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) as been signed by the a 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ØUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No has page, this certificate 1 ☐ Yes or Attending Physician: the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification; To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 283 65 30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print)

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month,

DHMH 17 Rev 1/2001

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32. Registrar's Signature

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	Physic /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Roger Barton				2. Oate of Death Month	Day Yea 8 200	3. Time of Death
,	Exami		4a. Facility Name (If not institution, give street and number) 22903 Civic Circle	- 1	b. City, Town, or I Smithsbu			4c. County of De	eath
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	irthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		Sirthplace (State or Foreign Country)
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	ryland how		10a. State 10b. County 10c. City, Tow	n or Locat	tion				10d. Inside City Limits
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	3a or 3	급	10e. Street and Number 22903 Civic Circle		10f. Zip Code 21.783			Citizen of What 0	Country?
920	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23e or 28e-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Morried 1 Yes, Give Year or Dates:	If Ye	s Decedent of His es, specify Cuban Yes 2 No	panic Origin? (Sp , Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Black
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and 2	e d la b	To Be C	17. Father's Name (First, Middle, Last) Edward Barton			8. Mother's Name	e (First, Middle, Maio e (unk)	den Surname)	
Mary	od 2::	۴	19a. Informant's Name/Relationship (Type, Print) 19b	d Number or Run	al Route Number, Ci gerstown,	ty or Town, State MD 2174	, Zip Code)		
Baltimore,	00		20a. Method of Disposition 1 During Surial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) Rose I			. Location - City o			
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ا م		-	27. Manner of Death 28a. Date of Injury 28b. T	itpatient 3 Fime of njury	28c. Injury a Work?		ne 5 Hesidence 28d. Describe how in		ecify)
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	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edicai (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge 2 Medicel Exeminer: On the basis of examination and manner stated.	death occurrence	curred at the time, igation, in my opin	date and place a	and due to the cause	(s) and manner a	s state burg
	To th To th comp	ž	29b. Signature and title of certifier		29c. License r			Date signed (Mon	
		-	30. Name and address of person who completed cause of death (Item 23a) (Tune D-	D3	847/		7/28/	05
H -	2		30. Name and address of person who completed cause of death (item 23a) (2.2	-911 Je	Ferso	Blud.	In 1ths.	bory m
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	/Medic		Melvin Bivings		07 2	4 05 DIDUPM
4	Examin	ner	4a. Facility Name (If not institution, give street and number) 4b. Ci	tity, Town, or Location of Death	4	County of Death
	Funeral		5-Social Security Nember 6. Sex 7. Age (In yrs. last birthday) If Un	nder 1 Year If Under 24 Hrs. 8.	. Date of Birth	9. Birthplace (State or Foreign
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	pug M		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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	r 28a	Director	DC 10e. Street and Number 10f.	Washingt Zip Code		itizen of What Country?
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	Hems :	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was De	ecedent of Hispanic Origin? (Specif specify Cuban, Mexican, Puerto Ric	fy Yes or No- can, etc.)	 Race - American Indian, Black, White, etc.
336	urs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 7 ☐ Widowed 4 ☐ Divorced Year or Dates:	s ZX No Specify:		Specify: Black
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Exama her must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of	Isual Occupation	16b. I	Kind of Business/Industry
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Maryland	s 1 and 2 should t f Health and Meni item 27 is marker other fraumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	ress (Street and Number or Rural R		
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Baltimore,	Pages 1 au nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	or Ozerden s		
Him			'4 □Donation 5 □Other (Specify) Heritage Mer 21. Signature of Fueral Service License 22. Name			Roebuck, SC neral Home
Ba	permit. Departr Imports any inji			01 Benning Rd.,		
			23a. Parth. Enter the disease, or complications that caused the death. Do not enter the m shock, of heart failure. List only one cause on each line.	node of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
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760,	ate be executed sysician and he burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):			
6876	The law requires that the death centificate be executed tie has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dical	d			
Вох 6	leath certificat attending phy I for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
	death e atte	icia	in the past 12 months? 1 Yes 2 No 1 Yes 2 No	c pregnancy (specify)		Month Day Year
P.0	that the de led by the a detached	Phys	3 CONKNOWN	ng gayan ayan in Part I	23e Did tobacco	use contribute to the cause of death?
ds,	signed signed d be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlyin	ig cause given in Fait i.		2 No 3 Probably 4 Unknown
Records,	w require been signature	lete			24a. Was an	24b. Were autopsy findings available
Re	The lav	Completed			autopsy performed? 1 ☐ Yes 2 🛣	prior to completion of cause of death?
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	ing After une	ion:	27. Manner of Death 1 Natural 5 Pending investigation 1 Natural 5 Natural 5 Mending investigation	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	d. Describe how inju	ury occurred
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Div	al or A s after if Direction by	Serti	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Star	(9)
	e Hospital or 24 hours afte e Funeral Dire etely filled in b	edicai (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur (Check only 2 Medical Examiner: On the basis of examination and/or investigat			
	To the Hos within 24 h To the Fur completely	Medi	one) and manner stated.	29c. License number		ate signed (Month, Day, Year)
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Δ	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)) 3,00%	J.	inly 24. 2005 lighten maryland
K	9		William T. TANNER MD. 11701 LIVE	ingeton Knd F	nt was i	lighten maryland
	Sta		31. Date filed (Month, Day, Year)	•		
	Registr	ar	JUL 2 7 2005 Bloke & grand			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Brittingham 5:25 P M 2005 23 July /Medical Facility Name (If not institution, glos street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner and Rehabilitation Worcester Cente Berlin Berlin Nursina If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign 6. Se 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**X** M 2□ F 80 April 11, 1925 Maryland Director 219-07-7280 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other than "natural", or items 23c or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes .2X☐ No Directo Maryland Worcester Berlin 10g, Citizen of What Country? 10f, Zip Code 10e. Street and Number 21811 USA 509 Flower Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status should be filed within 72 hours after 1 XI Yes 2 1 No. If Yes, Give 1943-46 Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Brittingham, Shumway and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Car Dealership laborer 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fassett John H. Brittingham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: if item 27 is any injury or other trainonce. 509 Flower Street - Berlin, Maryland Evelvn Brittingham/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) • 4 □ Donation Paul UM Ch. Cem. 07/30/2005 Berlin, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Similare of Funeral Service Licensee JOLLEY MEMORIAL CHAPEL 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dehudration Physician /Medical Due to (or as a consequence of): inaritition **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner erebovasculor accident physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 by Physician/Medicai as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, runertersion 1 ☐ Yes 2 ☐ No 3 Probably 4 Hinknown Completed diabetes nelitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performe 1 ☐ Yes 2 (L) N To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ 10 4 Nursing Home 5 Residence 2 6 ☐ Other (Specify) this 28d, Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification; 1 Natural 5 Pending after death.

I Director: Aff 2 🗆 No investigation 1 Tyes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 To the (DE) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier C1-0006795 -24-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FEMULCI ISUANO, DE GRIFFIN COMTAL HIGHWAY MD 1209 NE agistrar's Signature State Registrar

Physici	an	1. Decedent's Name (First, Middle, Norris B. Cart							2. Date of Dea Month AUG.	th 2005	Year	3. Time of 1920	Death P
/Medic Examir		4a. Facility Name (If not institution, ROUTE# 85 1/2 mi		ADAMST	OWN RD	^{4b} ADAMST(or Location of	f Death		frede			
Funeral Director		5. Social Security Number 216–38–0478	6. Sex 1 🛣 M 2 🗆 F	7. Age (In yrs.	last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Oct. 27	Year) 7,1940	9. Birthp Cour Vir	olace (State o ntry) ginia	r Foreig
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Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; eny injury or other traumatic event, the Medical Exe once.	mpleted	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	's Education t grade completed) College (1	-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most ed)			16b. Kind of B		_{dustry} Indust	27.7
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year MAVIS BEVERLY COOK 4:52 P M JULY 25 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CARROLL HOSPITAL CENTER WESTMINSTER CARROLL 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2X F Months 216-22-8603 **Director** MARYLAND 8/26/1927 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other treumatic event, the Medical Exeminer must be notified at Director 1 ☐ Yes 2X No MD CARROLL WESTMINSTER 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code "neturel", or Items 23e 341 MARGARET AVE. 21157 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. TELLER BANK 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H lent: If item 27 Is marked otl Be GILBERT BROWN **EVA** SHIPLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other treu LEVINE L. COOK -HUSBAND 341 MARGARET AVE., WESTMINSTER, MD. 21157 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Commetery, crematory or other place)

SANDY MOUNT CEMETERY 7/29/05 SANDY MOUNT, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Libensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 .23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CRITICAL **Physician** AORTIC STENOSIS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed HONDANCEC Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Yes 2 X No the 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Wasan has autopsy 200 No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Medical Certification: To 1 ☐ Yes 2 X No Other 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 2 ☐ Accident 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by 4 Thomicide after To the Hospitel within 24 hours a To the Funerel I Hospitel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) asuniva WIL 7-25-2005 51705 apleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 10 Westminstor, M. PANSURIYA DR 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State Registrar

		. 101	partment of Health and Me ertificate of Death	ental Hygie	2005 26193
Physi	ċian	Decedent's Name (First, Middle, Last) GEORGE SAVERIO CHEFFI	:	2. Date of Death Month July	Day Year 24 2005 3:58 A M
/Med Exam		GEORGE SAVERIO CHEFFI 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July	4c. County of Death
LAGIN	iiiiei	Harford Memorial Hospital	Havre de Grace		Harford
Funera	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country)
Directo	r	Usual Residence of Decedent		March 4,	1942 Boston, MA
land ow		10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits
Many If sh	į	MD Prince George's Laurel			1 ☐ Yes 2X No
with the Maryland a or 28a-f show	Funeral Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
23a	rai	13302 Santa Anita Road	20708		U.S.A.
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itied within 72 hours after death with the Maryland Higieneih Higieneihen "natural", or Items 23a or 28a-f show ant, the Medical Exam nat must be notified at	by Fi	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
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Ped De S			4739 Baltimore Aven		· ·
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or Attend after death Director:	fica Ea	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		Bf. Location (Stree	at and Number or Rural Route Number,
after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	State)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, I	edicai C	29a. Certifier Certifying Physicien: To the best of my knowledge, de: (Check only 2 Medical Exeminer: On the basis of examination and/or			
o the Ithin 2 o the	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
F 3 F 8			DGP768	7	7/24/05
2/2		30. Name and address of person who completed cause of death (Item 23a) (Type	06268	10,1	1
(4)		M. Johnda, 281 E Man & fu	3 July 1900 11	711	
Regis	tate strar	31. Date filed (Month, Day, Year) JUL 2. 7 2005	Ti)		

DHMH 17 Rev 1/2001

State Registrar

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Otis Lee Conyers 25,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye 11/25/ 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** M 2□ F 242 16 2984 89 Director Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any jointry or other treumetic event, the Musical Examplest must be nutified at once. 10c. City, Town or Location 10a, State 10b. County Mitchelliville P.G. MD Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9705 Bald Hill Road 20721 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, enyers, Oti 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xo Specify: þ 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Ministry Pastor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cynthia Holiday William Kidd Conyers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9705 Bald Hill Rd Mitchellville, Md 20721 daughter Lynda R. Nix 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glenview Cemetery 7/30/05 Durpham, NC 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Snead Mortuary Service, P.A. 21. Signature of Funeral Service Licensee 1409 Fairlakes Pl Suite B Bowie, Md 20721 23a. Part1. Enter the obsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 211eeners /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to apath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **X**No 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certifica funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

7:23A M

Birthplace (State or Foreign Country)

Black

Approximate Interval Between Onset and Death

USA

Month

29d. Date signed (Month, Day, Year)

Day

3 Probably 4 Unknown

Year

South Carolin

10d. Inside City Limits

1X Yes 2 No

To the Hospitel
within 24 hours a
To the Funerel E

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month,

certifier

4 T Homicide

29a. Certifier (Check only one)

29b. Signature an

6201 Greenhe 32 Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

and manner stated.

ORIGINAL

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

		1	For State Registrar	State of	of Maryla	•	rtment of F	lealth and i Death		iene 	26196			
DI	nysicia	_	1. Decedent's Name (First, Midd						2. Date of Deat		3. Time of Death			
/	Medic xamin	al -	HSING-SHIEN 4a. Facility Name (If not institution	CHANG	ım <i>ber</i>)		4b. City, Town, o	r Location of Death		4c. County of De	5:30 P M			
-	Kannın	eı	WASHINGTON ADV	, 3	·		TAKOMA			MONTGOM				
	neral ector		5. Social Security Number 214-74-9704	6. Sex 1 M 2 ☐ F	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day APRIL 1	Year)	Birthplace (State or Foreign Country) CHINA			
D			Usual Residence of Decedent			Sites Town and a				. ,	10d. Inside City Limits			
Aaryla	N N		10a. State 10b. Count MARYLAND MONT	GOMERY		City, Town or Lo					1 ☐Yes 2 ☐ No			
h the h	mont	ပ္ –	10e. Street and Number	JOHENI	10	DOK V I II II	10f. Zip Code		1	0g. Citizen of What	Country?			
ath wit	ast by		12916 LARKIN P				208			UNITED STATES				
.0036 hours after death with the Maryland turel: or thams 23a or 28a-f show	the Medical Extrainer outside at	by Fur	11. Marital Status 1 □ Never Married 2 Ma 3 □ Widowed 4 □ Divorce	rried Armed F	2 X No ive	1	Was Decedent of F Yes, specify Cuba	dispanic Origin? (S an, Mexican, Puert Specify:	pecity Yes or No- to Rican, etc.)	Black, W	merican Indian, hite, etc. WHITE			
21215-0036 ad within 72 hours at giene.	alls.	Completed		nt's Education est grade completed,)	(Give	lent's Usual Occup kind of work done OO NOT use retired	during most of wor	rking	16b. Kind of Busines	ss/Industry			
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Via Mer		2	S. L. CHANG 19a. Informant's Name/Relation	schip (Type Print)	-	19h Mailin	Address /Street	A-SHC		ONG r, City or Town, State	Zin Code)			
	other treumatic		_	DAUGHTER			•	L TERRACE		OD, MARYL				
Ps 1	- 10 I		20a. Method of Disposition 1 X Burial 2 Premation	3 Demoval from		Place of Dispo	sition (Name of natory or other pla	св)	Date	20c. Location - City	or Town, State			
Baltimor	any injury o		'4 □Donation 5 □ Other (Specify)	PA	- 1		PARK 7/			E, MARYLAND			
Balt permit. Departr	any ir		21. Signature of Furreral Service 23a. Part1. Enter the disease, shock or heart failure L	M./2	ru.	11	70 ROCKV	ILLE PIKE	E, ROCKVI		INC. 20852			
Exam	purial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a consi	equence of):	Jun.	g Cav	1 Cev		Onset and Death			
Box 6	detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of preg birth 2 Te gnant at time of nown	ital death 3 [Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year			
ds, P.	5,2	by	Part II, Other significant condi	tions contributing to	death but not r	esulting in the u	nderlying cause giv	ven in Part I.			to the cause of death? Probably 4 Unknown			
	nas be ge 2 sh	Completed							24a. Was a autops perfor	sy prior	autopsy findings available to completion of cause of ? es 2 \(\square\) No			
of Vital Physician: T	rector, pag	Be	25. Was case referred to medic examiner?	Hospital: 3		C=0.0	Ott	her	ath (Check only or					
Phys of	uneral di	ation: To	1 Yes 2 No 27. Manner of Death Natural 5 Pend 2 Accident inves	28a. Date	•	ER/Outpatier 28b. Time o Injury	28c. Inju	4 Nursing F		ence 6 ⊡Other (S ow injury occurred	оөспу)			
Si fter	ed in by the f	Certification:	3 Suicide 6 Coul 4 Homicide deter	minord 200, Flat	ce of Injury - At ding, etc. (Spe	home, farm, str cify)	eet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,			
To the Hospitel within 24 hours a	completely filled in by	edical (29a. Certifier (Check only one) Certify	ring Physicien: To the al Exeminer: On the and the	ne best of my k basis of exami nner stated.	nowledge, deat nation and/or in	n occurred at the ti vestigation, in my	ime, date and place opinion, death occi	e, and due to the durred at the time, d	cause(s) and manner date and place, and d	as stated. Jue to the cause(s)			
To the within	comple	Me	29b. Signature/and title of certif	ier M	100	N	29c. Licen:	se number	8 =	Suly 22	onth, Day, Year)			
	10		30. Name and address of person	on who completed can	use of death (II	em 23a) (Type.	Print)	Ave #3	37, Silve	V Spring	MD20902			
R	Sta legistr	_	31. Date filed (Month, Day, Yea JUL 2		Registrar's Sig	mature A	mile		,	4 0				

KENNETH R. CASTEEL G5-05057

RKD			For State		State	of Marylar					and M	lental Hy	_	2.0 ==		_	
		1 34	Registrar 1. Decedent's Name	e (First Middle	Last)		CE	ertificat	e or	Deam		2. Date of D	Reg. No	005	25 9	<u> </u>	
	Physici	an	1. Decedent's Name	Kenneth	, Lasi,	Raymond		Casteel				Month TITY	Day 27.	Year	4:33A.	М	
	/Medic Examin		4a. Facility Name (I		give street and nu					r Location o	f Death	JULI		County of Oeath	14:33A.		
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	i Funeral		5. Social Security N		6. Sex 1 ★ M 2 □ F	7. Age (In yrs.	-	/) If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Birth Cou	place (State or Forei	ign	
	Director	K.	215-98-8834		IKIM ZUF	23	Yrs.					09/06/	1981	Mary			
4	and w		Usual Residence of 10a. State	10b. County		10c. C	ity, Town or L	ocation							10d. Inside City Limi	ıts	
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	uth with the Maryla 23a or 28a-f sho	Director	10e. Street and Nur	· · · · · · · · · · · · · · · · · · ·	<u> </u>			10f. Zip	Code				10g. Citize	en of What Cou	ntry?		
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36	s afte	y Fu	1 X Never Marri 3 Widowed		ed 1 X Yes If Yes, Gi Year or D	2 □ No ve Dates: 20(13	1 🗆 Yes	2 X No	Specify:			9	Specify: Whi	to		
21215-0036	within 72 hours after death with the Maryland ene. 90e. This "hefures", or Items 23a or 28a-f show the Madical Exacilization of the Incitified at	Completed by		15. Decedent'	's Education		16a. Dec	edent's Usua	al Occup	pation			16b. Kind of Business/Industry				
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213	0.5	Com	12]	Electri	cian			Merchant Marines					
2	Iryland should be file of Mental Hy marked oth martic svent		17. Father's Name	(First, Middle, L			0	1				(First, Middle	, Maiden S				
<u>2</u>			Kenneth	(D-(-4)h	Wayne		Castee.		/Ct t	Kris		Jo	City of	Andrews			
<u> </u>	re, Mai Tand 2 st Health and tsm 27 is r		19a. Informant's Name/Relationship (Type, Print) Kristi Jo Casteel / mother 19b. Mailing Address (Street and Number 2884 Finzel Road, Frost Finzel Road)											0 (000)			
	Baltimore, Mapernit. Pages 1 and 2.5 Department of Health at Important: If itsm 27 is any injury or other trau		20a. Method of Disp		, moener	20b.	Place of Disp	osition (Nar	ne of			Date	_	ation - City or T	own, State	-	
Baltimore, permit. Pages 1 ar peparant of Heal mportant; if item in my layer or other and in the my layer.				☐ Cremation 5 ☐ Other (Sp	3 Removal from	State	cemetery, cre .lcrest				8/01/	2005	Cumbe	rland, Ma	arvland		
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			23a. Part 1. Enter the shock, or hea	ne disease, or on the failure. List of	complications that only one cause on e	caused the dea	th. Do not er	nter the mod	le of dyir	ng, such as	cardiac c	or respiratory a	ırrest,		Approximate Interval Between		
	Pnysician	8 8	Immediate Cause disease or condition	(Final n	- a.	DSI	Ohu	XIZ	_ ,	tron	J-11	otic			Onset and Death	(3)	
	/Medical Examiner		resulting in death)	7	Due to	(or as a cons	uence of	Secretary of	1								
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-	\mathcal{O}_{I}	1	30. Name and addr	ess of person v	who completed caus	se of death (Ite		, Print)	anni and	Marchannes Ca	D A T 1771						
	nRs		31. Date filed (Mon	th.10an Year)	0 200F 32.F	tenistrar's Sign	11	1		KEET,	DALL	TMOKE I	IAKILA	ND 2120) <u>T</u>	-	
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			Ficase	• •	Department of Health and N		•	
			1 - For State Registrar	State of Maryland	Certificate of Death	Reg.	000=	26198
		П	1. Decedent's Name (First, Middle, La	ast)		2. Date of Death	Day Year	3. Time of Death
	Physici /Medi		Evelyn c	1. Dargan		7 2	6 05	17:18 M
	Examir	ier	4a. Facility Name (If hot institution, gi	ve street and number)	4b. City, Town, or Location of Death	20/32	4c. County of Death	
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. last b	intriday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	Prince 9. Birth	place (State or Foreign
	Director		247-64-9455	10M 20XF 68	Yrs. Months Days Hours Min.	(Month, Day, Ye	37 Desh	lington, S.C
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Toy	wn or Location			10d. Inside City Limits
	Maryli f eho	lor	Md arines	Comes Ten	who thelle Med 20	740		1 Des 2 □ No
	r 28a	Director	10e. Street and Number	34195 1011	10f. Zip Code	10g.	Citizen of What Co	untry?
	23a c		2900 Saint (lair Dr. #	515 20748		U5A	
	er dea itams	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
336	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f ehow te Medical Exerting termster culting at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: 3	lack
21215-0036	72 hou	eted	15. Decedent's E (Specify only highest gr	ducation 16a	a. Decedent's Usual Occupation (Give kind of work done during most of work	sina 16b	. Kind of Business/l	ndustry
2	within iene.	Completed	Elementary/Secondary (0·12)	College (1-4or 5+)	life. DO NOT use retired)	1	And C	200
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an	ould be Mental arkad o	To Be	Shirley de	eche	Appla	6 Ghr	-	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hyglene. Itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Exer, it or traust the rightlind at	-	19a. Informant's Na e/Relationship	(Type, Print USDand) 19	b. Mailing Address (Street and Number or Rui	ral Route Number, Ci	ty or Town, State, Z	ip Code) 20748
-	and 2 ealth m 27 I		My Wille 1).	Darian Sr.	2900 Saint Clair	Dr. 75%	5 Temple	Hills INC.
lore	8 ± = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State	of Disposition (Name of ery, crematory or other place)	Date 20c	. Location - City or I	own, State
Baltimore	t. Partmer rtant rtant njury		* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	1/ 011	22. Name and Address of Facility	0/05 /1	FXGHANI	2011
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			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death. Do	not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
M	Physician		Immediate Cause (Final disease or condition	· Myocardiol	Infarction			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):	lar bise		
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	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C				
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6876		dlcal	•	d				
Box 6	certifi nding use as	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliv	/ery
	death e atter	iclar	in the past 12 months?	1 Live birth 2 Fetel death	h 3 Ectopic pregnancy 5 Other (specify)		Month	Day Year
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Vital	ian: T rtificat ctor. po	0	25. Was case referred to medical		26. Place of Deat	1 ☐ Yes 2 Д th (Check only one)	NO 1 195	2
of V	Physician: r this certificatal director.	To B	examiner? 1 ☐ Yes 2 2 No		The second secon	ome 5 Residence		ify)
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Ö	ai or / s after ii Dira	Serti	4 Homicide	building, etc. (Specify)		City or Town, St	ate)	
	To the Hospital or Attending Physician: The law Within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier (Check only 2 Medical Exe	hysicien: To the best of my knowledg	e, death occurred at the time, date and place, nd/or investigation, in my opinion, death occur	and due to the cause	e(s) and manner as	stated.
	the Hin 24 tha F	Medi	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month	
)	Jiw S		250. Signature and title or certains	of trup	0003706	6 0	7-27-20	205
Δ	(2)		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print) 6188 0401 0 000 HIL	NHIII	1 # Zn1	
1	-6		UCHECHI T. C	PALGBEOGU, M	D OXON HIL	L M	20	745
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 8 2005	32. Registrar's Signature		/		
DH	MH 17 Rev 1/2		00L % 0 2003	Been & A	and I			
2.11		,		ORI	GINAL			

			For State Registrar	State of M	aryland	•	artment of H			giene Reg. 20 ()5	26199	
	Physici	an	1. Decedent's Name (First, Middle	, Last)					2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medic		MARGARET	М.	D	ARBY			JULY	25 20	05	7:00 A M	
	Examin	er	4a. Facility Name (If not institution			400	4b. City, Town, or			4c. County			
			14801 PENNFIEL 5. Social Security Number		# je (in yrs. las	409	SILVEF	If Under 24 Hrs		MONT			
	Funeral Director		220 12 8883 Usual Residence of Decedent	1 M 2 ⊠ F	80	Yrs.	Months Days	Hours Min	. (Month, Da	10, Year) 16,1925		place (State or Foreign Intry) Ginia	
	ylanc how		10a. State 10b. County			Town or Lo						10d. Inside City Limits	
	Ba-f-	cto	Md. Montgo	omery	S.	ilver	Spring				1 Yes 2 No		
	라 다 or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of	itizen of What Country?		
	ath v	rai	14801 Pennfield		09	140		906	2	United			
10	i within 72 hours after death with the Maryland liene. r than "natural", or Iteme 23a or 28e-f ehow the Medicel Eranical must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? ed 1 Yes 2		. 13.	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Pue	to Rican, etc.)	Bla	14. Race - American Indian, Black, White, etc.		
98	urs a	٥	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1☐ Yes 2⊠No	Specify:		Specify: White			
Maryland 21215-0036	72 ho	Completed	15. Decedent (Specify only highes				dent's Usual Occupa		orkina	16b. Kind of B	usiness/lr	ndustry	
21	within ene. then "	mpl	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired,)	9				
121	a filed w Il Hygier other ti		12 17. Father's Name (First, Middle, I	0	1_	Hom	emaker	18 Mother's No	me (First, Middle	Own I			
anc	d la la la la la la la la la la la la la	Be c	100	arthy				Helen	Thom				
<u>F</u>	s 1 and 2 should by Heelth end Menta tem 27 le marked other treumatic ev	은	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street a		-		State, Zi	p Code)	
	olth e					1967							
ē,	s 1 and 1 Heel		1 M Burial 2 Cremation 3 C Removal from State						le,Silve	20c. Location	City or T	own, State	
E	Pages nent of l ant: If its ury or o						- '		29/05	Bealls	ille	, Md.	
Baltimore,	permit. Page Depertment of Important: If any injury or once.		21. Signature of Funeral Service I				208	82					
			21. Signature of Funeral Service Licensee Muriel H. Barber							rrest,		Approximate Interval Between	
	Pnysician :		Immediate Cause (Final disease or condition			7-17	22					Onset and Death	
	/Medical		resulting in death)	a. Respira Due to (or as	a conseque	nce of):						l Week	
	Examiner		Sequentially list conditions.	D			cell lung	cancer				l year	
	pe #is	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se	a eurreaque	riea of):							
_	te be executed ysicien and e burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	a conseque	nce of);							
8760,	sicien buria	calE			·	,							
687	ficate physics the			d									
Вох	eath certifica ettending ph I for use as th	Physician/Med	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome			Tetasia asamana.			23d. Da	te of deliv	ery	
	deat	sicia	in the past 12 months? 1 Yes 2 ZNo	1 □Live birth 4 □ Pregnant at 9 □ Unknown			Ectopic pregnancy Other (specify)			Mo	onth	Day Year	
P.0	at the de I by the o	Phys	9 🗆 Unknown										
Records,	The law requires that the death certificate tie has been signed by the ettending phys age 2 should be detached for use as the	by	Part II. Other significant condition Colon cancer	ns contributing to death b	out not result	ing in the u	nderlying cause give	on in Part I.				the cause of death?	
ecc	e taw re has be	Completed							24a. Was		Were auto	opsy findings available	
8		Som							perfo 1☐ Yes	rmed?	death? 1 🗌 Yes	2□ No	
Vital	Physician: T this certificat ral director, pa	Be (25. Was case referred to medical examiner?						ath (Check only o				
of	Physi this c	P.	1 ☐ Yes 2 ♣ No	Hospital:		R/Outpatier	100	4 Indising	Home 5 Resi			fy)	
n (ion	27. Manner of Death 1 XNatural 5 ☐ Pendin		y Year)	8b. Time of Injury	Work	at ?? ∕es 2 □ No	28d. Describe	how injury occur	red		
Division	deat deat ctor: / the	ficat	2 Accident investig	ot be 200 Place of le	iury - At hom	ie. farm. str	eet, factory, office	63 20110	28f. Location (Street and Numi	er or Run	al Route Number,	
Ε	after de Direct	Certification:	4 Homicide	building, et	c. (Specify)				City or To				
	To the Hospitel or within 24 hours after Volte Funerel Director Completely filled in b	Medical C	29a. Certifier (Check only one) 1 Certifyin 2 Medical	g Physicien: To the best Exeminer: On the basis o and manner st	f examinatio	ledge, deatl on and/or in	n occurred at the time vestigation, in my op	e, date and plac sinion, death occ	e, and due to the urred at the time,	cause(s) and modate and place,	anner as s and due t	stated. o the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	_			29c. License	number		29d. Date signe	d (Month,	Day, Year)	
			fund	M/len	nel	0	D3599	96		July 26	, 200	05	
	10		30. Name and address of person Linda M. Burre	who completed cause of o			Print)				902		
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2.				barli						

		Please	State of Ma				c. Ensure A Health and I	-	_	ble.	
		1 - For State Registrar	State of Ma	arylanu		tificate of			Reg. No. 2 ()	0.5	26200
Physic		1. Decedent's Name (First, Middle, La	st) (1) [1]	an		a y		2. Date of Dea Month July 2	ith Day	Year	3. Time of Death 3:30 a M
/Med Exam		4a. Facility Name (If not institution, giv	e street and number)	, ,		4b. City, Town,	or Location of Deat		4c. County		3.30 a
		Future Care - Ol	d Court				allstown			timo	
Funera Directo		213-42-3031	Sex 7.Ag I□M 2反F	e (In yrs. Ia.	st birthday) Yrs.	Months Days	r If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jul 24			lace (State or Foreign try) 'yland
aryland show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Los		Randallst	OV-TO		1	0d. Inside City Limits 1 ☐ Yes 2⁄∑ No
the M 28s-f	Director	Maryland Balti 10e. Street and Number	more			10f. Zip Code	Natioalls		10g. Citizen of \	What Coun	
th with	a Di	5412 Old Court R	oad				21133			USA	•
d 21215-0036 filed with the Maryland filed within 72 hours after death with the Maryland Hygiene. Whysiene. The Maryland is the mest 23a or 28a-1 show ant, the Medical Experiment must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:			/as Decedent of Yes, specify Cul ☐ Yes 2☑ No	Hispanic Origin? (S ban, Mexican, Puerl o Specity:	pecify Yes or No- o Rican, etc.)	14. Rac Blac Specify	e - Americ ck, White,	
A- V 15-0036 72 hours att	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced	ent's Usual Occu	upation e during most of wor ed)	rking	16b. Kind of B	usiness/Inc	dustry
2121 ad within giene. er then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. D	00 NOT use retire Homemak		de de la companya de	Огл	n Hom	e
flaryland 212: 2 should be filed within and Mental Hygiene. Is marked other than reumatic event, the M.	Be Co	17. Father's Name (First, Middle, Last						ne (First, Middle,	Maiden Suman	ne)	
/lar	TO B	Walter Columbu	ıs Allen				Henri	letta Lea	ah Lands	sberg	
FPY ore, Maryland is and 2 should be file is the and marked oth item 27 is marked oth		19a. Informant's Name/Relationship (****				et and Number or Ru				
e, N Health em 27		Walter R. Day, s	son	20b. Pla			19th Avenu		20c, Location -		
Page nent g		1 ☐ Burial 2 ☑ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif	5)	Car	roll	ition (Name of atory or other pla Crematic	ons 07/2	21/2005	Hamps	-	
Balt Balt Departs Imports Imports eny inji		21. Signature of Funeral Service Licer	nsee M	00723		Name and Addr	1	Eline Fur		_	74
		23a. Part1. Enter the disease, or com	plications that caused	the death.			th Main St			2 210	Approximate
Physiciar /Medica		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		Prio.		erosi	<u> </u>			-	Interval Between Onset and Death 25 Years
Examine		Sequentially list conditions,	b. Due to (or as								
60, be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c								
Box 68760, eath certificate be executed attending physician and for use as the burfal-transit	Sai	Cooking in County 225.	Due to (or as	a conseque	ence or);				-		
Division of Vital Records, P.O. Box 687 To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the tuneral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal c	death 3□	Ectopic pregnand Other (specify)	су			te of delive	ny Day Year
ds, P. nires that t signed by		Part II. Other significant conditions	contributing to death b		-	derlying cause g	iven in Part I.	23e. Did to			e cause of death?
COT www.requ	Completed by	Serile	den		-			24a. Was a	an 24b. 1	Were autor	psy findings available
I Re The Is ate has	mo							autops perfor 1 Yes	med? /	death?	npletion of cause of 2□ No
/ita clan: ertifica	Be (25. Was case referred to medical examiner?						th (Check only or			
of \Physical This cal direction	10	1 ☐ Yes 2 ☑ No 27. Manney of Death			R/Outpatient	3LI DOA		ome 5 Reside)
On (ding I	tion	1	28a. Date of Inju (Month, Da	y Year)	Injury	28c. Inju Wo M 1	uryat ork?]Yes 2∐No	28d. Describe h	ow injury occur	rea	
Division of Vital Records, or attending Physician: The law requires that death. Director: After this certificate has been signed in by the tuneral director, page 2 should be done.	Certification:	3 Suicide 6 Could not be determined		ury - At hom c. (Specify)	ne, farm, stre	et, factory, office)	28f. Location (S City or Town		er or Rura	l Route Number,
e Hospite 7 24 hours le Funeral	edical C		nysician: To the best miner: On the basis o and manner sta	f examination							
To the Yeithir To the comp	Me	29b. Signature and title of certifier	t.a	9	ン	D O	nse number	964	29d. Date signer	200	Day, Year)
	HIM	30. Name and address of person who									
*		Jerome Ginsberg, 31. Date filed (Month, Day, Year)		Libe		laza, Ra	andallstow	m, MD 21	_133		
S Regis	tate trar	JIII 2.5 2	A	ar s Signatu		a. N. 2					

			For State Registrar	State of	Maryland /		artment of				iene	2005	2000	
			Decedent's Name (First, Middle,	Last)						2. Date of Deati	h	Vana	3. Time of Death	h
	Physici /Medic		IVY	DUNCAN						JULY	21	2005	1:51 A	√M
	Examin	er	4a. Facility Name (If not institution, WASHINGTON A	-			4b. City, Town, TAKO		of Death			ounty of Death	v	
	Funeral			3. Sex 7.	Age (In yrs. last b	oirthday)	If Under 1 Year	If Under		8. Date of Birth				aign
:	Director		125-48-1749	1 □ M 2½ F	70	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day, JANUARY	11	JAMAI	ace (State or Fore try) CA	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	ocation					10	Od. Inside City Lim	nits
	a-f sh	tor	MD PRINCE	GEORGE'S	BE	ELTS	VILLE						1 X Yes 2 □	No
	or 28	Director	10e. Street and Number				10f. Zip Code			10	-	on of What Coun	try?	
	ter death with the Marylan Items 23a or 28a-f show Inch. Ust be multied at	eral	11319 NARROW T	RAIL TERRA		13	20705	Hispanic Or	igin? (Spa	cifu Ves or No-		. S . A .	an Indian	
980	a of	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☒ Divorced	Armed Force	eş? ∐XNo		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 🔀 No			Rican, etc.)		Black, White,		
2-0	72 hours "natural",	eted	15. Decedent's (Specify only highest	Education grade completed)	16	a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during mos	st of workin	ng .	16b. Kind	d of Business/Ind	ustry	
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)			ed)			77			
	Hyg Hyg otha	0	17. Father's Name (First, Middle, L.	ast)		но	ME MAKER	18. Moth	er's Name	(First, Middle, N		IVATE umame)		
/lan	0 0 0	To B	THOMAS GRANT					EST	ELLA	ALLIS	ON			
, Maryland	ges 1 and 2 should t of Health and Mer If Itam 27 Is marke or other traumatic		19a. Informant's Name/Relationshi ORDETTE GLASS/				ng Address (Stree 7 NARROW							705
Baltimore,	Pages 1 announce of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spi		ate cemet	ery, crei	esition (Name of matory or other pla COLN CEM	1				ation - City or Tor ${ m TWOOD}$, MA		
alti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Li			_	2. Name and Addr					S FUNERA		
-	20 5 2 2		000000000000000000000000000000000000000	3	1		474 LAND					ARYLAND	20785	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nty one cause on eac	as a consequence	Tu	Solm	ing, such as	Scardiac of	hode		,	Approximate Interval Between Onset and Death	
	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence	La	lenstra)m's	esse N	mens laenogle	bin	aemi		
8760,	icate be e physiciar s the buris	lcal		d						0				
.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Fetal dea nt at time of death		Ectopic pregnand	БУ			23	d. Date of deliver	ry Day Year	
s, P	es tha	by	Part II. Other significant condition	s contributing to deal	th but not resulting	in the u	nderlying cause g	iven in Part	l.		acco use		e cause of death?	
Vital Record	aw 2 slb	ompleted	Caro	11)my1	shalt	1	<			24a. Was ar		24b. Were autop	sy findings availa	ible
Ä	The ate h page	Com			1		=			perform	ned?	death?	No	Ji
Vita	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:			To		e of Death	(Check only one	∍)			
ō	Phys ral di	1: To	1 Yes 2 No 27. Manner of Death	28a, Date of	Injury 28b	Outpatier . Time o	IL 3LI DOA			ne 5 Reside		Other (Specify occurred))	-
ion	Attanding of death. actor: After by the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury		ork?]Yes 2.[]No					
Division	or affe in	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Hornicide determin	ed 286. Place of	Injury · At home, , etc. <i>(Specify)</i>	farm, sti	eet, factory, office		2	8f. Location (Str City or Town		Number or Rural	Route Number,	
	ĕ = = ≥	edical (Physician: To the base and manner	is of examination a									
	To tha P within 24 To the F complete	W	29b. Signature and title of certifier	//			29c. Licen	se number	47	29	d. Date	signed (Month, L	Day, Year)	
12	(4)		30. Name and address of person w					01	1-1-		-	/ /		
	Sta	ite.	Nasreen M. Kans	go M.D. 76	00 Carro pistrar's Signature	11 A	venue Ta	koma	Park,	Maryla	nd 2	0912		
\$ 1. \$	Regist		JUL 2 7 201	15 Bleet	JA J	ton	K)							
DH	MH 17 Rev 1/2	001			- /									

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N2 0 0 5 26202
Ph	ysicia	an	1. Decedent's Name (First, Middle, Last) ELMER DAUGHERTY 2. Date of Death Month Day JULY 25, 2005 3. Time of Death 2:00 P M
	Medic amin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Eus	eral		15205 GARDNER ROAD WALDORF CHARLES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign)
Dire			5. Social Security Number 401-82-4033 401-82-4033 401-82-4033 401-82-4033 401-82-4033 401-82-4033 401-82-4033 401-82-4033 401-82-4033 401-82-4033 401-82-4033 401-82-4033 51 51 51 51 51 51 51
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. thygiene.	報	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
1d 21215-0036 e filed within 72 hours after death with the Marylan at Hygiene. other than "natural", or items 23a or 28a-f show	notifie	Director	MD Charles Waldorf 1 □ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ath with	ed lie		15205 Gardner Road 20601 U.S.A.
ter dea	mar m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
215-0036 ithin 72 hours at ne. nen "natural", or	Exam	δ	3 □ Widowed 4 □ Divorced Specify: Specify: White
215-(10 72 h 10 "natu	Wedler	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
d 21, filed with Hygiene the the	ar in	Com	12 Police Officer U.S. Government
d la b	0	To Be	17. Father's Name (First, Middle, Last) William Daugherty Gladys Blankenship
re, Maryle s 1 and 2 should of Health and Mer item 27 is marke	trauma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ore, Nest the of Health fitem 27	other		Brenda Daugherty - Spouse 15205 Gardner Road, Waldorf, MD 20601 20a. Method of Disposition (Name of commetery, crematory or other place) 20b. Place of Disposition (Name of commetery, crematory or other place)
Baltimore, permit. Pages 1 ar Department of Hea Important: If item i	any injury or once.		'4 Donation S Other (Specify) Huntt Crematory 07-30-2005 Waldorf, MD
Balt permit. Depart	any in		21. Signature of Funeral Service Licensee M00053 Hant Funeral Home P.O. Box 156, Waldorf, MD 20604
1843	÷		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Operat and Death
Physic /Med			Immediate Cause (Final disease or condition resulting in death) ATHERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):
Exami		_	
cuted	ansit	Examine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c
ate be executed hysician and	burial-ti	ai Exa	resulting in death) Last Due to (or as a consequence of):
by at W	as the	Medicai	d.
Geath certific e attending p	for use	cian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
	stached	Physician/M	9 Unknown 9 Unknown
ords, P.O. requires that the	peq	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
as b	CVI	ompieted	24a. Was an autopsy findings available prior to completion of cause of
- - - -	<u>α</u>	e Cou	performed? death? 1 Yes 2 XNo 1 Yes 2 No 25. Was case referred to medical 26. Place of Peath (Charle only one)
- × ×	e dire	ToB	25. Was case referred to medical examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify)
On O			27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury Work? 1 Notice Injury Month, Day Year) 1 Notice Injury 28b. Time of Injury Work? 1 Yes 2 No
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	by the	ertification;	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Spital o	9	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
the Ho hin 24 h	npletel)	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Viiti To	00	_	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JULY 27, 2005
(Ect			30. Name and address of erson who completed use death (Item 23a) (Type, Print)
DOV	Stat	te	Eugene Taylor, M.D., 5100 Auth Way, Suitland, MD 20746 31. Date filed (Month, Day, Year) JUL 2 7 2005 32. Fegistrar's Signature
Re	gistra	ar	JUL 2 7 2005 Straw & Sparks

State of Maryland / Department of Health and Mental Hygiene State Registramend item #8 per fh 2846 8/3974 is cate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Warren Arthur Denler July 25 6:30 P M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 XM 2 ☐ F Yrs Director 382-16-7284 84 Apri1 1921 Michigan Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "netural", or Items 23a or 28e-f ahow any injury or other traumatic evant, Ite Mexical Examiting Intelligible at ONCE. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland St. Mary's Charlotte Hall 1 Yes 2 No Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20622 29449 Charlotte Hall Rd. USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: White þ 3√ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Major U.S. Army 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Denler Grace McDaniels 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruby Garcia/Personal Representative 43480 Drum Cliff Rd., Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 28, 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crematory 2005 Charlotte Hall, MD 21. Signature of Funeral Service Lig 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A., 30195 Three Notch Rd., Charlotte Hall, MD Approximat 20622 Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner 27. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certiticate be executed Orony sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 2 or Attanding Physiclan: certific tuneral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No 1. Inpatient 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours atter deal To tha Funaral Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)606 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Rd., Prince Frederick, MD 20678 Mathur, 31. Date filed (Month State Registrar

			1- State of Maryland / Department / Department		, ,	jiene •9. 2 . 0 0 1	5 26204
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Dear Month	th	3. Time of Death
	/Medic	al	David Vernon Drinks 4a. Facility Name (If not institution, give street and number) 4b. C	ity, Town, or Location of Death	July	24,20 4c. County o	05 5:45A M
	Examin	er		La Plata			harles
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un	der 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day)		MARYTEAND OF Steign
	Director		217-42-3700 TXM 2 F 63 Yrs. Mont	1000	July 7		Wäshington
	yland now		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	e Mar	ctor	MD Charles Newburg	5			1 ☐ Yes 2 ☐ No
	h with th	Funeral Director	10e. Street and Number 11345 Popes Creek Road	Zip Code 20664	1	0g. Citizen of Wr USA	nat Country?
0000	within 72 hours after death with the Maryland ene. Than "natural" or Items 23a or 28a-f ehow ha Madical Exactinar must be notified at	by	Armed Forces? If Yes, s	cedent of Hispanic Origin? (Sispecify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		- American Indian, , White, etc. White
7-CIZI	within 72 h ane. than "natu	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	work done during most of work	king	16b. Kind of Bus	aterman
iang z	e filed al Hygi other vent, I	o Be Co	17. Father's Name (First, Middle, Last) Lester Drinks	18. Mother's Nam	a Halfp	Maiden Sumame,	
, mary	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e ocea.		Robyn Inks/Personal Rep. P.O. B	ess (Street and Number or Ru lox 123, Abe	11,MD 2	0606	
Saltimore	Pages 1 tment of He tant: If iter		MARCHE	or other place) 1n Cem. 7/2	8/05 B	ladens	burg, MD
מ	Departition Depart		21. Signature of Funeral Service Licensee AR P 23. Part1. Enter the disease, or complications that caused the death. Do not enter the n	Pand Address of Facility EHART-ECHOLS D. BOX 567 I	FUNERA A PLAT	AL HOME	E,P.A. 20646
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the new shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	node of dying, such as cardiac	or respiratory arro	est,	A proximate Interval Between Onset and Death
8/00,	icate be executed EX physician and Executed Extended Executed Exec	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	wn.			
O. Box 68	ath certifi titending or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknow	c pregnancy (specify)		23d. Date Monti	,
cords, P.	ss that gned b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.			oute to the cause of death?
Ľ	The transparent	Completed			24a. Was a autops perform	ned? pri	ere autopsy findings available or to completion of cause of ath? Yes 2 \(\) No
VIII	iding Physician: th. : After this certifica ; funeral director, p	Be	25. Was case referred to medical examiner? Hospital:	0.4	th (Check only on	6)	
ō	Phy al c	T: To	27. Manner of Death 28a. Date of Injury 28b. Time of	YM Training I	ome 5 Reside	ence 6 Other	
VISION	nding ath. r: Afte e func	atlor	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		,,	
DIVIS	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fac building, etc. (Specify)	tory, office	28f. Location (St. City or Town	reet and Number n, State)	r or Rural Route Number,
	he Hospi in 24 hour he Funer: pletely filli	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurr 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.	ed at the time, date and place, ion, in my opinion, death occur	and due to the carred at the time, da	ause(s) and mana ate and place, an	ner as stated. Id due to the cause(s)
^	To t To t	Σ	29b. Signature and title of certifier	29c. License number	2	9d. Date signed ((Month, Day, Year)
1	84		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Hexands	Febre	en s	20937
	Sta	te	31. Date filed (Month, Day, Year) 7 2005 32. R distrar's Signature	16.0			

			1 - State of Maryland / Department of Health and M Certificate of Death		iene ⊶№ՈՈ5 26205
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) TEAN BAILOR EYERS 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2. Date of Dea	Day Year 3. Time of Death 28, 2005 5, 50 AM
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Nov 22,	MONTGOMERY 9. Birthplace (State or Foreign Country)
	D	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes ② ☐ No
	s 23a or	Funeral Directo	10209 Garden Way 20854		0g. Citizen of What Country?
980	ours after de rai', or item Examinar	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto in If Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho ene. than "netu ne Madical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry
Maryland 2	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than "netural", or items eumatic event, Ir a Madical Examiret m	Be	17. Father's Name (First, Middle, Last) Howard Collins Bailor 18. Mother's Name Marjory	(First, Middle,	Own Home Maiden Surname)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparment of Heatth and Mental Hygiene. Importants if Item 27 is marked other than "netural", or items 23a or 28e-1 show any injury or other treumatic event, it a Madical Examinar must be notified as once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 10b. Mailing Address (Street and Number or Rural 20c. Method of Disposition (Name of cemetery, crematory or other place) 10c. Mailing Address (Street and Number or Rural 20c. Method of Disposition (Name of cemetery, crematory or other place)	Montgome	
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr once.		21. Signature of Funeral Service Licensee Coing Home Cremation MO1251 Beverly L. Heckrott	n Servi	
2	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	or respiratory arr	est, Approximate Interval Between Onset and Death
8760,	cate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any leading to intrinciate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
.O. Box 6	death certific e attending p id for use as	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delivery Month Day Year
rds, P	w requires that the been signed by the should be detache	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	pacco use contribute to the cause of death? as 2 No 3 Probably 4 Unknown
al Records,	The law ate has b page 2 st	Complet		24a. Was a autops perform	
ion of Vital	Attending Physician: The death. ector: After this certificate by the funeral director, pag	atlon; To Be		me 5□Reside	e) nnce 6 Other (Specify) w injury occurred
Division	i Sir de	Certification;	4 Homiciae building, etc. (Specity)	City or Town	
	To the Hospitel within 24 hours a To the Funeral I completely filled	l edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my death occurred and manner stated.	ed at the time, d	ate and place, and due to the cause(s)
	To To com	W	29b. Signature and title of certifier 29c. License number		July 28, 2005
20	62		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anushiravan Dadgar, D.O. 9715 Medical Center Dr. #201	Rockvil	le, MD 20850
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 9 2005 32. Registrar's Signature		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. 2.005 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** HILDA LOUISE ENSOR 22, 4:10 P M JULY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CONTINUUM CARE SYKESVILLE CARROLL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 😡 F Director 85 8/8/1919 MARYLAND 218-32-8868 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f ehow any njury or othar traumatic avant. It a Marked Evanted from 10 and 2006. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director CARROLL WESTMINSTER MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 HOOK RD. 21157 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOR SHOE FACTORY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY WADE HUGHES BESSIE SUSANNAH SHIPLEY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA H. ENSOR-DAUGHTER 310 HOOK RD., WESTMINSTER, MD. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BOSLEY CEMETERY 7/26/05 SPARKS, MD *4 ☐ Donation 5 ☐ Other (Specify) paral Service Licenses 22. Name and Address of FacilityFLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD.21157 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, other lifailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration disease or condition resulting in death) /Medical Due to (or as a conse uence of): Examiner che worth Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) the ģ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed neec 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ₩6 has l certificate 2 No 1 ☐ Yes To the Hospital or Attanding Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours after To the Funeral Dira 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatur and title of the Nie 29d. Date signed (Month, Day, Year) MD WJZ IU17 52 5001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Progress Way 17002 1380 1745 such 106 Ecoensburg MD 31. Date filed (Month, Day, Year) State Registrar JUL 2 6 2005

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 5:41 **Physician** 1 2005 August Alvin Roy Edwards /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Clinton Prince George's Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) 1930 District of Columbia 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1(X) M 2□ F 74 Yrs Director September 14. 578-40-3499 Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ont: If item 27 is marked other than "neturel", or Items 23a or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "neturel", or Items 23a or 28e-f show treumatic svent, I're Modical Experiment is ust be notified at 1 ☐ Yes 2XXNo Director Maryland Saint Mary's St. Inigoes 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20684 18276 Waterview Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∑Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Repair Telecommunications 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Fred Roy Edwards Della Victoria Burroughs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rebecca Alice Edwards / Wife P.O. Box 97, St. Inigoes, Maryland 20684 20b. Place of Disposition (Name of cometery, crematory or other place)
Maryland Veterans Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State August ō * 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 5, 2005 Cheltenham, Maryland 22. Name and Address of Facility 21. Signatuse) of Funeral Service Licensee Mattingley-Gardiner Funeral Home, P.A. Thichael Keving P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician meumonia days /Medical Examiner na Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed ears Division of Vital Records. P.O. Box 68760. care Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 🗌 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 2 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this After this funeral c 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day 27. Manger of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 24 hours a 18 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier cai the within To the 29d, Date signed (Month, Day, Year) 29b. Signature and itle of certifier 0 of person who completed cause State Registrar

			1 - For Stete Registrar	State of Maryl	and / Depa <i>Cei</i>	artment of F	Health and N	lental Hyg	iene	- 0
	Physi /Med		Charlie	J. Forsyt	he, Jr	•		2. Date of Dea JMPyh23,	29 9 5 Ye	3. Firmer of Death 8:54 A
	Exam	3- 5- et	Prince George's Hos	pital		Cheve	-		4c. County of t	Death
	Funera Directo		241-40-5465 Usual Residence of Decedent	1 M 2 □ F 74	yrs. last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) May 20,	9. 1931 No	Birthplace (State or Foreig Country) Orth Carolina
	eath with the Marylan te 23s or 28s-f show That be notified at	Director	MD Prince	George's	City, Town or Loc Suitl					10d. Inside City Limits 1 □ Yes 2 □ No
	ath with	rai Dir	10e. Street and Number 4504 John St	reet		10f. Zip Code 2074 (5	1	Og. Citizen of What	t Country?
9003	after d or item	d by Funerai	11. Marital Status 127 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1	1f	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🛣 No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A	American Indian, Vhite, etc. Black
Maryland 21215-0036	filed within 72 hours Hygiene. Ither then "naturei", int, it e Medical Exp	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12) 12	Education trade completed) College (1-4or 5+)	(Give k	ent's Usual Occup rind of work done of O NOT use retired Cleaner	during most of work	ng	16b. Kind of Busine	•
yland	a ia b	To Be (17. Father's Name (First, Middle, La. Will Forsythe			ozeaner	18. Mother's Name	e (First, Middle, N	faiden Sumame)	9
	12 m		19a. Informant's Name/Relationship Douglas J. Joyne	r–Son	4504	John Str	and Number or Rura	l Route Number,	City or Town, State	e, Zip Code)
Baltimore,	Page ent o nt: # ry or		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	□Removal from State ify) M	. Place of Disposi	ition (<i>Name of</i> ato <i>ry or other plac</i> i	9)	ate 2	Oc. Location - City Vashingto	
Bal	Department Department important:		21. Signature of Funeral Service Lice	E. Call	11/1 4	JU4 ZOLI	DL - N F	nette &	Assoc. F	uneral Home
60,	Physician / Medical Examiner sthe pural-transit	ıl Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused the de y one cause on each line. a. ARPERIOSCI Due to (or as a consi Due to (or as a consi c	equence of):				st,	Approximate Interval Between Onset and Death
P.O. Box 68760,	t the death certif by the attending ached for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	tal death 3 □E death 5 □ C	ctopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
ords,	w requires that been signed I should be det	Ď	Part II. Other significant conditions Dishetes MALT	es Encepha	lopam	erlying cause giver	n in Part I.	23e. Did toba		to the cause of death? Probably 4 Unknown
ital Rec		Be Completed	Nechotizing Fas Respiratory Fan 25. Was case referred to medical						prior to	autopsy findings available completion of cause of es 2 \sum No
vision	To the Hospital or Attending Physiciam: within 24 hours elet death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Certification: To I	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At I	28b. Time of Injury	3 DOA Other 28c. Injury a Work? M 1 Ye	at 28	e 5 Residence Rescribe how If. Location (Street	injury occurred	ecify) Bural Route Number,
	he Hospital o in 24 hours af he Funeref Di plelely filled in	Medical Cer	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exar	ysician: To the best of my kn niner: On the basis of examin and manner stated.	Outladge death -	ocurred at the time tigation, in my opir		City of Town, 3		
)	To the To the Complete	Σ	29b. Signature and title of certifier	Devere		29c. License r			Date signed (Mon	
R	4		PAUL A. DEVO	completed cause of death (Itel	m 23a) (Type, Prir	RUPL PA	1852 Hum	50,71-	mh 20	781
# R	Star Registra		31. Date filed (Month, Day, Year) JUL 2 8 2005	a. Hogistian 3 Signi	ature Sparks		19-177116	46		-31

			State of Mary	land / Depa	artment of He	alth and M	ental Hvg	iene	
		1 - For State Registrar	,		rtificate of D			2005	26209
Q .		1. Decedent's Name (First, Middle,	Last)				2. Date of Deat Month	h Day Year	3. Time of Death
Physici /Medi		Elmer	L.	For	d		07-27-2		11:28 PM
Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County of Dea	
		27231 Fairmount			Fairmou			Somerse	
Funeral Director			1 X M 2□F	yrs. last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign country)
		219-14-4127 Usual Residence of Decedent	80				03/14/1	925 Mar	yland
ryland how		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
e Ma	cto	Maryland Some	set	Fairmou	nt				1 Yes 2 □ No
ith th	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	country?
s 23e	rai	27231 Fairmour		- 11.0	21867		- * - * - * - * - * - * - * - * - * - *	USA	-desa ladica
ter de	Funerai	11. Marital Status 1 ☐ Never Married 2 Marrie	12. Was Decedent Ever Armed Forces?	In U.S. 13.	Was Decedent of Hisp f Yes, specify Cuban,	Mexican, Puerto I	Rican, etc.)	14. Race - Am Black, Wh	
urs af	þ	3 Widowed 4 Divorced	ed 1 A Yes 2 □ No If Yes, Give Year or Dates: WW	II I	1 ☐ Yes 2 ☑ No	Specify:		Specify:	Thite
72 ho	Completed	15, Decedent' (Specify only highest	s Education	16a. Dece	dent's Usual Occupation	on ring most of working	20	16b. Kind of Busines	
ithin ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	ing most of working	,9		
tygier herti		7 17. Father's Name (First, Middle, L	none	W	aterman	8. Mother's Name	(First Middle A	Seafood	
d be fi	Be							raiden Sumame)	
ally idition Z I Z I 300030 should be filled within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or Items 23s or 28e-1 show maric event, the Modical Exemplational be notified at	2	Eldridge Olin F		19b. Mailir	ng Address (Street and	lanche R		City or Town, State.	Zip Code)
IVIC nd 2 stalls as allth as 27 is r treu		Minnie French I	Ford/Wife		l Fairmoun				
othe othe		20a. Method of Disposition	2	Ob. Place of Dispo	sition (Name of natory or other place)	D	ate :	20c. Location - City o	r Town, State
Pege nent c		1 Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp	3 Memoral Ironi State		d Cemetery	07/30	/2005 1	Princess A	nne, MD
portition of the first profile A 12 13 10000 permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23s or 28e-1 show appringing or other treumatic event, the Maddal Examinational be notified at once.	1	2 Signature of Funeral Service S	icensee	H-	Name and Address Lnman Fune:	of Facility			
		MEST SILK		00295 1	1673 Somer	set Ave.	, Prince	ss Anne,	MD 21853
		23a. Part 1. Enter the disease, or o shock, or heart failure. List of	complications that caused the only one cause or each line.	death. Do not ent	er the mode of dying,	such as cerdiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
Pnysician	6	Immediate Cause (Final disease or condition resulting in death)	_a. [7e	lasta	un l.	nota	le Ca	neer	11 years
/Medical Examiner			Due to (or as a co	nsequence of):					
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	nsequence of):					-
cuted Id	Examiner	triat irritiated events	6						
ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):					
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	dicai	13	d						
leath certifical	Physician/Med	IF FEMALE:	23c. If yes, outcome of pr	rognancy				V	
atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Blivery Day Year
the d	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown						
uires that the devisions to signed by the a	by PI	Part II. Other significant condition	ns contributing to death but no	t resulting in the u	nderlying cause given	in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
w require been sig			· · · · · · · · · · · · · · · · · · ·				1 ☐ Ye	s 212No 3□P	robably 4 Unknown
le law requires been ge 2 should	Completed						24a. Was ar	24b. Were a	utopsy findings available completion of cause of
The Table hade	Con						perform	ned? death? No 1 ☐ Ye	
vician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:			6. Place of Death	(Check only one	9)	
ding Physician: The ding Physician: The ding function of the f	To To	1 Yes 2 No	1 Linpatient	2 ER/Outpatien		4 Nursing Hon		nce 6 Other (Spewinjury occurred	ecify)
ding f After funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig		ar) Injury	Work?	s 2□No	.00. 00001100 110	W IIIJary Cocarroa	
Atten r deal sctor	ifica	3 Suicide 6 Could n	ot be 28e. Place of Injury	At home, farm, str	eet, factory, office	2	8f. Location (Str	eet and Number or F	lural Route Number,
s after sell or Certification:	4 🗆 Hottlicide	building, etc. (S	респу)			City or Town	, State)		
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After complately filled in by the lune lune.	edicai	(Check only 2 Medical E	Physician: To the best of my xaminer: On the basis of exa	knowledge, death	occurred at the time, vestigation, in my opin	date and place, a	and due to the ca	use(s) and manner a	s stated. e to the cause(s)
thin 2 the 1 the 1	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License n			d. Date signed (Mon	
¥ ¥ ¥ 8		1/1	The / terr	- 1m/	1000	1567	76	2/29/	05
		30. Name and address of person v	who completed cause of death	(Item 23a) (Type,	Print)	7 - /	/ -	1/2//	5
		Robert L. Cli	iton, MD		E. Carro	11 5t.,	A-1 -	alishury	MD 21801
Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature		•		,	
Registi	ar	AUG (2 2005 See	m K	Beech				

Amended Item 16a per F.D. 07/26/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	FOR	partment of Health and Mertificate of Death		2005 26210	
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death	
п	Physicia /Medic		Kenneth Robert Flowers		July 23	Day 2005 Year 6:00 A. M	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			3807 Fernside Road	Randallstown		Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 1 \boxtimes M 2 \square F 7. Age (In yrs. last birthdom 212-32-5386 1 \boxtimes M 2 \square F 68 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) NOV. 14,	(Year) 9. Birthplace (State or Foreign Country) PA	1
	pu >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			10d. Inside City Limits	
	anyla shov	2				1 ☐ Yes 2½ No	
	88-f	ecto	Maryland Baltimore Randal		10		
	with the port	급	10e. Street and Number 3807 Fernside Road	10f. Zip Code 21133		g. Citizen of What Country? United States	
	seth	eral		1		14. Race - American Indian,	_
Maryland 21215-0036	d within 72 hours after deeth with the Maryland jien. Then "naturel; or liems 23e or 28e-f show The Medical Exam or must be mailfied at	by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Ma	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc. Specify: White	
Ö	2 hou	ted	15. Decedent's Education 16a. De	edent's Usual Occupation	. 10	6b. Kind of Business/Industry	_
715	within 72 ene. then "n	ple	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use reti blesigner	ing		
21	d with	Completed	12th	Florist Desinger /m		Don Flowers Florist	
pu	e filed al Hygid other vent,	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	aiden Sumame)	
<u> a</u>	utd b Menta Irked Itic e	2	Emory Kenneth Flowers	Rita K.	Trostle		
ar)	s 1 and 2 should be filed if Health and Mental Hyg item 27 is marked othe other treumatic event,		1 1 21 1	iling Address (Street and Number or Run	al Route Number,	City or Town, State, Zip Code)	1
_	1 and 2 Health Iem 27 i				andallst		
ore	of He		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of rematory or other place)	Date 2	0c. Location - City or Town, State	
Ē	Pag ment ent:		'4 □Donation 5 □Other (Specify) Mt. Oli	e UM Ch. Cem. July	26, 200.	5 Randallstown, MD	
Baltimore,	permit. Pages 1 s Department of He importent: if item any injury or oth		21. Signature of Funeral Service Ligensee	22. Name and Address of Facility Burrier-Queen Funer 212 W. Old Liberty	al Home Road S	& Crematory, PA vkesville, MD 21784	9
			23a/Part1/Enter the disease, or complications that call on the death. Do not shock, or heart failure. List only one cause in each line.				
	Prrysician	6 16	Immediate Cause (Final disease or condition	· CA		Onset and Death	90
	/Medical		resulting in death) Due to (or as a consequence of):				
Е	Examiner		Sequentially list conditions, b.	112 12 22 22 2			
	sit ad	lner	if any, leading to immediate cause. Enter Underlying Cause Disease or injury				
	be executed sicien and burial-transit	Examln	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	be ey icien buria	a E	230 10 (01 00 0 00100400100 01).				
687	physi physi s the t	dlcal	d				_
×	The law requires that the death certificate be executed tte has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Вох	atter of for u	clar	in the past 12 months? 1 ☐ Yes 2 ☐ No	Ectopic pregnancy Other (specify)		Month Day Year	
Ö.	at the de by the a tached	lys	9 Unknown				
٣.	res that igned b	by Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?	
rds	quire in sig uld b				1 🗌 Yes	2 No 3 Probably 4 Onknown	
Records,	s been s been s shoul	Completed			24a. Was an		
Re	The lav	E O			autopsy perform 1 Yes 2	prior to completion of cause of death? No 1 Yes 2 No	
Vital		0	25. Was case referred to medical	26. Place of Deat	th (Check only one		_
\geq	ysic is ce direc	9 9	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	Other	ome 5 Viesider		
Jo C		n; T	27. Mann of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Inju		28d. Describe how	v injury occurred	
Ö	ttendin death. ctor: Af y the fur	atlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			_()
Division	or Attendate death Director: /	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 6 ☐ Could not be building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)	1
Q	oitei c urs af rei D lled ir	Cel					
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, description on the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the car red at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)	
	とうと S	M	29b. Signatur and title of certifier Willer MI	29c. License number D 35 39	29	d. Date signed (Month, Day, Year)	
	W8 * 141		30. Name and address of person who completed cause of death (Item 23a) (Ty	e, Print)	1 2001	1 1 1 1 1 1000	
			FlAVID MUTER MD 555 Soul	- h Center Street	- West	Water MOUID)	_
			31. Date filed (Month, Day, Year) 32. Registrar's Signature				

			1 - For State Registrar	tate of Maryla			of Hea	alth a			iene .g. No. 2 (005	26211
	Physici	an	Decedent's Name (First, Middle, Last)						and the same of th	Date of Deat Month	Day 21	Year	3. Time of Death
	/Medic	al	Donald Cliftor			11.03				July		2005	6:45A [™]
	Examin	er	4a. Facility Name (If not institution, give street 408 S. Springdale			4b. City, To		Wind:				ty of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 \	Year If	f Under 24	4 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
	Director		705-14-0244 1IXM	2□F	85 Yrs.	Months D	Days	Hours	Min.	Dec. 2,	1919	Mar	yland
	w		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	cation						11	Od. Inside City Limits
	f sho	ō	Maryland Carroll		,,		Wind	dear				"	1 ☐ Yes 2 ☐ No
	28a-	rect	10e. Street and Number			10f. Zip Co		u 501		1	0g. Citizen o	f What Coun	itry?
	th with	Funeral Directo	408 S. Springdal	e Rd.				2177	76			U.S.	Α.
	ems errin	Iner	T	Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Deceden	t of Hispa	anic Origi Mexican.	in? (Spec	cify Yes or No-		ace - Americ lack, White,	
36	or H	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give		1 □ Yes 2	,	Specify:		, , , , , , ,	Spec		nite
9	within 72 hours after death with the Maryland ene. then "netural", or items 23a or 28a-1 show ta Medical Exaciliat must be notified at	ed b	15. Decedent's Educati	Year or Dates:	16a, Dece	dent's Usual C	Occupatio	on.			16b. Kind of	Business/Inc	
215	hin 72	plet	(Specify only highest grade co	mpleted) College (1-4or 5+)	(Give	kind of work of DO NOT use i	done duri retired)	ing most o		ig .			
2	ygiene	Completed	7			machin						railro	ad
and	be fill d oth sven	Be	17. Father's Name (First, Middle, Last)				18			(First, Middle, M	Maiden Suma	ame)	
3	hould d Mer narke natic	J.	Russell C. Fritz 19a. Informant's Name/Relationship (Type,	Drint)	10h Mailis	on Address (C	Y			Field	C'tara Tara	- Ch. 4- 7'-	0:41
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "netural", or items 23a or 28a-1 show appring to other treumatic svent, the Medical Exacting must be notified at once.		Kathryn L. Fritz/wi	•						New Wi			•
Baltimore,	item item		20a. Method of Disposition	20b.	Place of Dispo	sition (Name	of					- City or To	
Ĕ	Page ment ant: If ant: If ury ou		1 Burial 2 ☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	State State	. Paul	s Luth	n. Ce					town,	MD
3alt	permit. Departi		21. Signature of Foneral Service Ligensee	X6 DO						zler Fu			
	7 D 7 8 0		23a. Part1. Enter the disease, or complicati	Mayor						v Windso		21//6	Approximate
	Physician /Medical Examiner physician up physician and physician and street physician street physician street physician physic	Examiner	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of): quence of): quence of):	1 in	lac	dis	Δ.				Interval Between Onset and Death
8760,	ate be e hysicier he buri	Ical											
O. Box 6	w requires that the death certifics been signed by the attending ph should be detached for use as t	Physiclan/Med	in the past 12 months?	If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregr						Pate of deliver	ry Day Year
σ,	s that gned b	by PI	Part II. Other significant conditions contrib	uting to death but not re	sulting in the u	nderlying caus	se given i	in Part I.		23e. Did tob	acco use co	ntribute to th	e cause of death?
ecords,	law requires as been sign 2 should be		Hypertens	un &	yperl	yard	en	<i>N</i>		1 🗆 Ye	s 2 No	3 🗌 Proba	ably 4 Dunknown
\mathbf{x}	The lay ate has page 2	Completed								24a. Was an autops perform	/	were autop prior to con death? 1 \(\text{Yes}	osy findings available inpletion of cause of 2 No
Vital	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ital: 1 Inpatient 2] ER/Outpatien	4 2C 50 4	Other			(Check only on			,
o	ding Physicien: h. After this certific funeral director,	-	27. Manner of Death	8a. Date of Injury (Month, Day Year)	28b. Time of		Injury at Work?	4 LI NUIS		e 5 Aeside 8d. Describe ho			"
ior	Attending r death. sctor: After y the fune	atlo	2 Accident investigation	(Worth, Day Feat)	Injury	м		s 2 No	0				
Division	l or Atto after de Directo	Certification;	3 Suicide 6 Could not be determined	8e. Place of Injury - At I building, etc. (Spec	home, farm, str lify)	eet, factory, or	ffice		2	8f. Location (Sti City or Town		nber or Rural	Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)	an: To the best of my kn On the basis of examin and manner stated.	nowledge, death action and/or inv	n occurred at t vestigation, in	the time, my opini	date and ion, death	place, a	nd due to the ca d at the time, da	use(s) and nate and place	nanner as sta e, and due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and little of certifier	11		290	icense nu	umber		29	d. Date sign	ed (Month, L	Day, Year)
)	WSV		100	1		XI	200	750	76	3	7/2	1/2	
	WY		30. Name and address of person who comp	eted cause of death (Ite	m 23a) (Type,	Print)) /	1 /	01	1,1001	1	10 10	141
		•	31. Date filed (Month, Day, Year)	OOZO 32. Registrar's Sign	6 46	F- FC	001	ex	d	WEST	MING	te V	11/32/15
	Sta Registr		JUI 2 5 201			land.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:45 A M JULY 22 2005 FOSTER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S 7713 MUNCY ROAD LANDOVER If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F ALABAMA MAY 14 1928 Director 417-34-7555 77 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral', or Items 23a or 28e-f show Examinar must be nutilied at 1 ▼ Yes 2 No LANDOVER PRINCE GEORGE'S Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 20785 U.S.A. 7713 MUNCY ROAD Funeral 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? XYes 2 No 1 ☐ Never Married 257 Married 1 ☐ Yes 2 🛣 No Specify Specify: Yes Give δ BLACK 3 Widowed 4 Divorced Year or Dates "netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 12th MILITARY SOILDER h and Mental Hygie filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HORTENSE FOSTER COOPER JAMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7713 MUNCY ROAD LANDOVER, MARYLAND FOSTER nt of Health a ANNIE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Pages 5 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or * 4 Donation 5 Other (Specify) ARLINGTON NATIONAL 7/29/05 ARLINGTON, VIRGINIA 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Lung Cancer Priysician /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed burial-transit and Due to (or as a consequence of): the attending physicien hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown detached The law requires that the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2√√ No 24a. Was an autopsy performed? page 2 2K No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 51X Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 2 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After Hospitel or Attending 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical npletely i 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Pay, Year) 29c. License numbe 29b. Signature and time of certifier 0 no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar
DHMH 17 Rev 1/2001

State

Ndegwa Njuguna M.D.

2 7 2005

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

vision of Vital

8901 Wisconsin Avenue Bethesda, Maryland 20889

			For State Registrar	State of Ma	ırylan				lealth a		-	giene Reg. No.	0.0	10.5	25	213
	Physici /Medic		1. Decedent's Name (First, Middle, Las Maria Eleanor C.								2. Date of De Month July 2	Day	005	Year	3. Time of 11:20	Beath A M
	Examir		4a. Facility Name (If not institution, give	_					Location	of Death			County			
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	h the Maryland r 28e-f show	ctor	D.C. none		Was	hingt	on						_		1 ₩ Yes	2 🗆 No
	with th	Funeral Director	10e. Street and Number				10f. Zi	Code				_		hat Coun	itry?	
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920	72 hours after death with the Maryland "neturel", or Items 23a or 28e-1 show dical Examinar must be notified at	þ	1 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2XN If Yes, Give Year or Dates:		1	If Yes, spe 1 ☐ Yes		Specify:		ecify Yes or No Rican, etc.)		Black	k, White,	etc.	
21215-0036	thin 72 ho e. en "netur M. dic II	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece (Give	kind of w	ork done	dunna mos	st of work	ing	16b. Ki	nd of Bu	siness/Inc	dustry	
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ylar	should be and Mental marked o umatic eve	To E	Tomas W. Flores								S. Col					
Maryland	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (7) Joseph J. Triolo/			1					Al Route Numb					
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E	Pages nent of ny		1 Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		1	e of	-		meter	July y 2	29. 005	Silv	er S	Sprin	g,Md.	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any Injury occither treumatic e once.		21. Signature of Fundal Server Liven	ell	,						Vol Fur W. Wash				20007	7
h	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition			h. Do not en	1	de of dyin		cardiac	•	rrest,			Approximate Interval Bet Onset and I	ween
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.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	Ideath 3	□Ectopic ; □ Other (s		,				23d. Date Mor	e of delive	•	Year
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Division	of or Attending Phaster death. I Director: After this in by the funeral	Certification:	3 Suicide 6 Could not b determined	28e. Place of Injubuilding, etc	ury - At h c. <i>(Specil</i>	ome, farm, st	treet, facto	ry, office			28f. Location (City or To			er or Rura	l Route Num	ber,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of the basis of and manner sto	examina	owledge, dea ation and/or in	th occurre nvestigatio	d at the tir	me, date a ppinion, de	nd place, ath occur	and due to the red at the time,	cause(s)) and ma d place, a	nner as s and due to	tated. the cause(s	;)
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			30. Name and address of person who	completed cause of d	eath (Iter	n 23a) (Type	Print)	Ovo.	#13	00	Che	vvC	has	o M	D 20	815
	St	ate	31. Date filed (Month, Day, Year)	32 Registr	ar's Signa	The Can	SUY(-116	.,	0()	9 1		J.J
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11:20 Am

Hores, Ma Ganor 1/25/05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Fersinger July 25, Marv 2005 1:32 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year_ Days Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Months Yrs. 80 1924 Director 578-26-3902 Scotland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28e-f show other treumatic avent, the Modical Execution count by notified at 1 ☐ Yes 🎾 No Director MD Charles Waldorf 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20603 U.S.A. 6170 Humpback Whale Ct. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) C&P Telephone Co. Administrative Assistant Pages 1 and 2 should be filed vent of Health and Mental Hygie int; If item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel S. Gray Jean Beaton McRobbie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John P. Fersinger - Husband 6170 Humpback Whale Ct. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 07-29-2005 Rockville, MD Parklawn Mem. Cemetery 22. Name and Address of Facility
Huntt Funeral Home
P.U. Box 156, Waldorf, MD 21. Signatura of Funeral Service Licensee M00053 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Immediate Cause (Final **Physician** Desseminated Intravascular 2 Arrs disease or condition Coajulopathy /Medical resulting in death) Due to (or as a consequence of) Examiner Ayocardia Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (6r as a consequ Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Coronar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 DN0 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division of Vital Records, P.O. Box 68760 Hospitel or Attending Physicien: within 24 hours a To the Funerel D

> State Registrar

Kobert Knox 31. Date filed (Month, Day, Year) JUL 2 7 2005

Coler

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7501 Survatta 32. Reistrar's Signature

and manner stated

Koad

29c. License number

MO: 00058600

Sirte # 303

29d. Date signed (Month, Day, Year)

7/26/05

			1 - For State Cate Cate Cate Cate Cate Cate Cate	,	artment of Health and M	Mental Hygien	2000
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month D	ay Year 3. Time of Death
h .	/Medic Examin	al	FRANKLIN DELANO 4a. Facility Name (If not institution, give street and not CIVISTA MEDICAL CENTER		FABER 4b. City, Town, or Location of Death LA PLATA	JULY 25	2005 10:52P M c. County of Death CHARLES
	Funeral Director		5. Social Security Number 6. Sex 1 № 1 № 2 □ F	7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Yea Sept. 18,	9. Birthplace (State or Foreign Country) Pennsylvania
	Maryland a-fehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland St. Mary's	10c. City, Town or Lo	ocation licsville		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
2-0036	be filed within 72 hours after death with the Maryland tal Hyglene dother than "naturel", or items 23a or 28a-f ehow event, the Madical Examinar must be multilled at	ted by Funeral Director	1 Never Married 2 Married 1 Yes 1 Yes 9 Year or I	orces? 2 No 1960 ive Dates: 1966	10f. Zip Code 20659 Was Decedent of Hispanic Origin? (Srif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 □ No Specify: dent's Usual Occupation	Decify Yes or No- Prican, etc.)	S. A. 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry
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ryland		To Be	17. Father's Name (First, Middle, Last) Mathias Joseph Faber 19a. Informant's Name/Relationship (Type, Print)	19h Maili		ne (First, Middle, Maide arriet Jen)	kins
re, Mai	s 1 and 2 should f Heelth and Mer item 27 is marke other treumatic		Jeanette M. Faber/wife 20a. Method of Disposition	2994	4 Burton Lane, Me	chanicsvil	
Бант	permit. Pages Depertment of I Important: if it any injury or o		1 Seurial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Maryland	Veterans cem. Jul 2. Name and Address of Facility Bri	nsfield-Ec	Cheltenham, MD hols Funeral Home,PA otte Hall, MD 20622
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Division	or Attending Piter death. irector: After in by the funera	Certification:	2 Accident investigation	nth, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	
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	To the Hospital within 24 hours of To the Funeral completely filled	Medicai	(Check only 2 Medical Examiner: Oh the	basis of my knowledge, deat basis of examination and/or in nner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	rred at the time, date a	nd place, and due to the cause(s)
}	Vill OT COD	4	29b. Signature and title of certifier	lle	29c. License number		Date signed (Month, Day, Year) ULY 26, 2005
3	BIGHT		30. Name and address of person who completed cau TERENCE BERTEL, M.D.		, Print) OD ROAD LEONARDTOV	N, MARYLAN	D 20650
	Sta	ate		Pigistrar's Signature	Court o		

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	Physici	an	1. Decedent's Name (First, Middle, Felix A. Gabi	•					2. Date of De Month	eath Day	Year	3. Time of	Seath O
	/Medic Examin		4a. Facility Name (If not institution,		ber)		4b. City, Town,	or Location of D	July 3		ounty of Deat	3:15	рм
			Holy Cross Hos	oital			Silver	Spring			onţgome		
L	Funeral Director		5. Social Security Number 580-98-2562 Usual Residence of Decedent	.Sex 1 1 1 M 2 □ F	7. Age (In yrs.	Yrs	If Under 1 Year Months Days		Min. (Month, Da	ay, Year)	9. Birti Co. 17 Domii	nplace (State o untry) nican Rep	r Foreign public
	ryland how		10a. State 10b. County		10c. Cit	ty, Town or Lo	ecation					10d. Inside Ci	
	he Ma 28a-f s	ecto	Maryland Monto	gomery		Silver	Spring 10f. Zip Code			10- 04-		1 ☐ Yes	2
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920	be filed within 72 hours after death with the Maryland ital Hygiene. Is dother than "naturel; or liems 23a or 28a-f show event, it me Medical Evarificet must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Yes If Yes, Give Year or Da	ces? 2 No		If Yes, specify Cub	an, Mexican, P	ominican		4. Race - Ame Black, White Specify: Whi	e, etc.	
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Maryland	C1 10 10 10		19a. Informant's Name/Relationship			1			or Rural Route Numb		,	lip Code)	
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Baltimore,	Pages ment o ent: If ury or		1 → Burial 2 → Cremation 3 `4 → Donation 5 → Other (Spe		tate	-	aven Cemete	1 0	July 28 2005	Silve	er Spri	ng,Mary	yland
Balt	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other		21. Signature of Funeral Service Li	BK		50	00 Univer	sity B	ns Funeral lvd, W, Si	llver	Inc Spring	, MD 20	0901
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Vital	Physician: Th this certiticate ral director, pag	BeC	25. Was case referred to medical examiner?	Hospital:			O#		Death (Check only o	one)			
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Division	el or Atters s after des la Directored in by the	Certification:	3 Suicide 6 Could no determin	ad 28e. Place	of Injury - At ho g, etc. <i>(Specif</i>	ome, farm, str (y)	eet, factory, office		28f. Location (City or To		Number or Ru	ral Route Num	ber,
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: Atter completely tilled in by the funer	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the I aminer: On the ba and mann	sis of examina	owledge, death tion and/or in	n occurred at the ti vestigation, in my	me, date and popinion, death o	place, and due to the occurred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	Yot withi To t	Ž	29b. Signature and title of certifier	Cita las	ladis		29c. Licen:				signed (Month		
•	7	1	30. Name and address of person will	no completed cause	of death (Item	n 23a) (Type,		3464	08, Rock		- 25 - 20		
	3		VIKRAHADINA. D. R	CDDY, 1112	Rock	LVILLE		SULTE 2	08, Rove	VILLE,	MD_ W	282	
	Sta Registr		31. Date filed (Month 1914), Your)	2005	gistrar's Signa	B. A	radi						i

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MABEL Μ. GARRISON JULY 25, 2005 1715 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY Montgomery General Hospital Olney If Under 1 Year | ff Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1□M 2€ F Director 216-40-8025 20,1928 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f shov traumatic event, the Modical Examiliar over be reciliad at Director 1 ☐ Yes 🎗 ☐ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3210 Norbeck Road, #222 20906 U.S.A. death Funerai 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No ff Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ Year or Dates: Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiene Important: If Itam 27 is marked other tha any injury or other traumatic event, the LORGE. Cook Private Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert H. Johnson, Sr. 2 Alberta Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 2353 Glenmont Cir, #202, Silver Spring, MD Joyce Garrison (Daughter) 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Donaton 5 ☐ Other (Specify) Mt 5 Other (Specify) ion Cemetery 8-1-05 Brookeville, MD 9 21. Signature of Funeral Service Licens 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Lung Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 Box 68760, Physician/Medical the as esn IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3€ Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2X No 1 Yes 2 No 1 Yes Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 ☐ Yes 2 ₹ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. fnjury at Work? 28d. Describe how injury occurred After 1 🔯 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the after death Diractor; 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by determined 4 | Homicide within 24 hours a 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) D35635 7-26-05 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) (5 Joseph Kaplan, 18111 Prince Philip Dr., Olney, MD 20832 M.D. 31. Date filed (Month, Pay, Year) 32. Signature State 2005 Parus Registrar

			1 - For State Registrar	State of Ma	ryland / Dep	ertificate of	lealth and	Mental Hy	giene	0.5	26219
	Physici	ian	1. Decedent's Name (First, Middle, Las	1)				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi	cal	Lioubov Goulis				1 22 45		27, 200		2400 P ^M
	Examir	ner	4a. Facility Name (If not institution, give Casey House	street and number)		Rockvil	r Location of Dea	itn		ty of Death gomer	**
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday) If Under 1 Year	If Under 24 Hr				y place (State or Foreign ntry)
	Director		212-51-9314 Usual Residence of Decedent	_M 2 X)F	75 Yrs.	Months Days	Hours Mir	Jan 4,	1930	Be1a	
	arylan show	_	10a. State 10b. County		10c. City, Town or L	ocation				1	10d. Inside City Limits
	8a-f	ecto	Maryland Montgome	ry	Takoma Pa						1 ☐ Yes 2X No
	with t	2	10e. Street and Number	16110		10f. Zip Code 20912			10g. Citizen of	What Cou	ntry?
	death	era	7620 Maple Avenue	12. Was Decedent E	ver in U.S. 13.	. Was Decedent of I If Yes, specify Cub	lispanic Origin?	Specify Yes or No	USA 14. Ra	ice - Americ	can Indian,
36	within 72 hours after death with the Maryland ane. than "naturel", or Items 23a or 28a-f show ha Medical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes ② N If Yes, Give Year or Dates:	0	If Yes, specify Cub 1 ☐ Yes 2 XNo		irto Rican, etc.)	Spec	ack, White,	
Maryland 21215-0036	2 hou	ted t	15. Decedent's Ed	ucation	16a. Deci	edent's Usual Occup	pation		16b. Kind of	Whi Business/In	
215	hlo 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5-	life.	e kind of work done DO NOT use retire	during most of w d)	orking			,
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pu	12 should be filed within h and Mental Hygiene. 7 is marked other than " raumatic event, the Med	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,	, Maiden Suma		
y la	nould 1 Men narke natic	ည	Yakov Kupraychek		[Maria			(UNK	
Mai	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (7 Tatyana Rubin/dau			ling Address <i>(Street</i> 3 Abrams (Code)
d)	1 and Health tem 27 other tr		20a. Method of Disposition	.8		nosition (Name of sematory or other pla		uly 29,	20c. Location		own, State
ΘĽ	ages ant of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		1	ematory or other pla el Cremato	1	uly 29, 2005	Odento		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Licent				9				x 784 e, MD 21029
	nysician /Medical Examiner	ilner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	a. Amyotrop1 Due to (or as a	θ.			ас от гөзрпатогу а	ilest,		Approximate Interval Between Onset and Death
Box 68760,	The law requires that the death certificate be executed as the bas been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	resulting in death) Last	Due to (or as a d. 23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	□Ectopic pregnanc	y			ate of deliver	ery Day Year
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Vital	ysician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?					eath (Check only o	one)		
of	ding Ph After th funeral	ation; To	1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatier 28a. Date of Injur (Month, Day	nt 2 ER/Outpatie y Year) 28b. Time Injury	of 28c. Inju	ner: 4 ☐ Nursing ry at rk? Yes 2 ☐ No	Home 5 Resident	dence 6 🗖 O how injury occu	ther (Specif	whospice
É	el or Attences after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ry - At home, farm, s . (Specify)	treet, factory, office		28f. Location (. City or Tox	Street and Nun wn, State)	ber or Rura	al Route Number,
	To the Hospitel or Attentwithin 24 hours after death to the Funeral Director; completely filled in by the	edical (29a. Certifier (Check only one) 1 Certifying Ph	vsician: To the best of iner: On the basis of and manner sta	examination and/or i	ath occurred at the ti nvestigation, in my o	me, date and place opinion, death oc	ce, and due to the curred at the time,	cause(s) and n date and place	nanner as s , and due to	tated. the cause(s)
	To the within 2 To the comple	W	29b. Signature and title of certific	1		29c. Licens	se number	10	29d. Date sign	ed (Month.	Day, Year)
)			CEURIO (in		\ \ \ \	4121	8	712	8/0	5
) 00	_		30. Name and address of person who charles Harrison	M.D. 6001	Muncaster	Mill Rd	. Rockvi	11e, MD	20855		•
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2005 32. R. Sstra	r's Signature	Courses					

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	9				(First, Middle	e, Last)				imoure				2. Date of Dea	ith		73_	3. Time of Death
	Physici /Medic			Marg	garet	Ther	esa	Gra	ham					July	15 ^{Day}	2	005	5:50P [™]
	Examir	er				n, give street an House	nd number)			4b. City, T		Location o			4c.	County of	Death eder	ick
	Funeral			Security Nu		6. Sex	7. Age	(In yrs. last	t birthday)	If Under	1 Year	If Under	24 Hrs	8. Date of Birt	h .	Т,). Birthol	ace (State or Foreign
	Director			-18-1		1□M 2X]F	83	Yrs.	Months	Days	Hours	Min.	Nov. 8,	19	21	New	York
	land Sw		Usual Re 10a. Stat	e sidence of l	Decedent 10b. County			10c. City, T	Town or Lo	cation							10	d. Inside City Limits
	Mary -f sh	tor	Mary	land	Fre	derick			Uı	nion E	Bridg	ge						1 ☐ Yes 2 No
	or 28e)irec		et and Num		·				10f. Zip	Code				10g. Citi	zen of Wh	at Coun	iry?
	ath w	ral	•	11726	Houck							2179					S.A.	
936	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23e or 28e-f show reumatic event, the Mcdical Examinar must be notified at	by Funeral Director		lever Marrie	d 2 Marr	ied 1 If Ye	Decedent E ed Forces? Yes 2 XN es, Give r or Dates:			Was Decede f Yes, speci 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:		cify Yes or No- Rican, etc.)		14. Race - Black, Specify:	White, e	an Indian, etc. ite
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e, N	1 and Health Sm 27 Iher tr			ıl Gra	ham -	son		20h Place		.6 Hou sition (Nam		d.,		n Bridge ate				C4-4-
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturary injury or other treumatic event, the Mudical QDGs.		1 X □	Burial 2 Donation	Cremation County		from State	cem	Pete	r's C	eme t	ery	7/19/	2005	Lib	erty	town	, MD
Bal	Depar Impor any in		21. Sighi	alure of Pun	eral Service	Lipensee	South	len	257	1802				rtzler Libert				
			sho	ock, or hear	failure. List	complications only one cause	that cause on each lin	the death. I	Do not ent	er the mode	of dying	, such as	cardiac or	respiratory ar	rest,			Approximate Interval Between Onset and Death
	Physician /Medical	1	disease	ite Cause (F or condition in death)	inal	a	My	000	rdu	1 1	SCV	1214	4				1	hours.
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of Vital Records,	To the Hospitet or Attending Physicien: The law in within 24 hours after death. To the Funerel Director: After this certificate has be completely filled in by the funeral director, page 2 sh	Comple												24a. Was autop perfor 1 Yes	sy	pri	or to con ath?	osy findings available apletion of cause of
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ion	ath. r: Afte	atio		Natural Accident	5 Pendin investi	gation	(Month, Day	Year)	Injury	М		? es 2 🗌	No					
Division	or Atte	Certification;		Suicide Homicide	6 Could determ	ined 286.	Place of Inju building, etc	ry - At home :. (Specify)	, farm, str	eet, factory,	office		2	8f. Location (S City or Tow	treet an n, State	d Number)	or Rurai	Route Number,
	pitet o		29a. Cer	tition	Cartifuir	a Physician: 1	Fo the best of	of any language				- 4-1	1					
	n 24 ho	edical		eck only	Medical	ng Physician: 1 Examiner: On and	the basis of manner sta	examination	and/or in	vestigation,	in my op	inion, dea	th occurre	nd due to the o	iate and	place, an	d due to	the cause(s)
	To the To the comp	ž	29b. Sigr	nature and t	itle of certifie		CGA	7	4.0	29c.	License	number	11					Day, Year)
	WIL			V	1	-2 H		1		7	4	41	04		(-	-18	1-0	כצי
	8		30. Name	e and addre	ss of person	who completed	cause of de	eath (Item 23	Fre	Print)	ck	M	0	2170	2	A.Z	H	EGAZi
•	Sta Registi		31. Date	filed (Month	n, Day, Year)		32. Registra	r's Signature	9									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year James Joseph Gallagher, Sr. 24, July 2005 0530 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct 26, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2□ F Director 214-22-4297 78 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show rerr. sast be notified at Westminster 1 ☐ Yes 2 No Director Maryland Carroll 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2882 Arters Mill Road 21158 **USA** Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. other traumatic event, the Mudical Exertine to 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 25 Married 1 ☐ Yes 2 ☑ No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced WII 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Fire Department Lieutenant 12 anould be fin th and Mental Hy 7 is mark 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lawrence C. Ennis Julia E. Frye 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Margaret G. Gallagher, wife 2882 Arters Mill Road, Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Carroll Cremations Hampstead, MD 07/25/2005 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FIBRILLATION /Medical FAILURE **Examiner** Sequentially list punditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No jo Day 4 Pregnant at time of death 5 Other (specify) ed by the a signed by be det Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed page 1 ☐ Yes 2 funeral director 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 1 Yes 2 10 1 Chipatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attanding 1 ENatural Injury 5 Pending after death. 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide filled in 24 hours a e Funaral I t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai To the Hosp within 24 hor To the Funa completely fi The destroying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) WIL D 18 200 25+IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700-A poole R

Registrar

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P.O. Box 68760

Division of Vital Records,

			For	State of Maryla					0 0 -	
			1 State Registrar		Ce	rtificate of	Death		. No 2005	26222
	Physicia		1. Decedent's Name (First, Middle, Las Robert W. Gatt, S	,				July 23,	Day 2005	3. Time of Death 8:20 p M
	/Medic Examin	- 11	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Death	P
ı			Civista Medical C			LaPlata			Charles	
	Funeral Director		5. Social Security Number 6. Sr 578-36-0996	7. Age (<i>In yi</i>	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Dec. 10,	(ear) 9. Birthp	place (State or Foreign
			Usual Residence of Decedent			l		Dec. 10,		ington DC
	arylar show	Ž	10a. State 10b. County		City, Town or Lo				1	0d. Inside City Limits 1 Y Yes 2 No
	the N	rect	Maryland Charles 10e. Street and Number	I	ndian H	ead 10f. Zip Code		100	J. Citizen of What Cour	
	filed within 72 hours after death with the Maryland Hygiene. yther then "natural", or tlems 23s or 28s-f show ant, the Medical Examinat must be notified at	Funeral Directo	14 Kenwood Place			20640)		ited States	•
	ems a	Iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.		dispanic Origin? (Si an, Mexican, Puert		14. Race - Americ Black, White,	an Indian,
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21215-0036	d within 72 hours after des giene. rr then "natural", or Items the Medical Examiner m	ted t	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	pation	16	b. Kind of Business/In	nite _{dustry}
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ang	ld be ental ked c	To Be	Walter William Ga					. Grooms	den Sumame)	
Maryland	should and Menis marke	1	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street			City or Town, State, Zip	Code)
	s 1 and 2 shou f Health and M Item 27 Is mar other traumati		Sarah Gatt-daught		2915	Hempstea	d Dr., F	t. Washing	gton, MD 20	744
altımore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ABurial 2 Cremation 3 C			osition (Name of matory or other pla			c. Location - City or To	
Ī			 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licenses 	des .		Cemetery 2. Name and Addre		27-2005 W	aldorf, Ma	ryland
ä	permit. Departr Importa any Inji	b H	Jock Al) MOTI	246 H	untt Fune	ral Home	MD 00	0.004	
Ĺ			23a. Part1. Enter the disease, or com, shock, or heart failure. List only	plications that caused the de	eath. Do not en	ter the mode of dyii	ng, such as cardiad	or respiratory arres	J6U4	Approximate Interval Between
	Pnysician	Ø V	Immediate Cause (Final disease or condition resulting in death)	a. Conge	twe	hea	et,	acter	Q	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):		/			
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	nd ransit	Examiner	that initiated events	C						
60,	cate be executed oblysician and the burial-transit		resulting in death) Last	Due to (or as a cons	equence of):					
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Вох	eath certific attending p for use as I	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred 1 Live birth 2 F		⊒Ectopic pregnanc			23d. Date of delive	ery
	e deat he att	Physician/Me	in the past 12 months?	4☐Pregnant at time of		Other (specify)	у		Month	Day Year
о. О	res that the de signed by the a be detached f		9 ☐ Unknown Part If. Other significant conditions of	ontributing to death but not	resulting in the L	ınderivina cause an	ven in Part I.	23e. Did toba	cco use contribute to the	he cause of death?
Division of Vital Records,	uires signe	d by	circhose	& live	人	as.ryg sauss g.v.			2 □ No 3 □ Prot	
000	law requira as been si 2 should b	Completed						24a. Was an	24b. Were auto	ppsy findings available
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lon	Attending Physician: Ir death. ector: After this certifice by the funeral director. I	atlon	1- Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year) Injury	Wo	rk?]Yes 2 □ No		,	
NS	or Attsn after deatl Director: in by the	Certification;	3 Suicide 6 Could not by 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	pital or ours afte erel Dir illed in		COn Continue 15 Continue Di	veloien. To the book of our						
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exer	ysician: To the best of my liner: On the basis of exam and manner stated.	ination and/or in	n occurred at the ti ivestigation, in my o	me, date and place opinion, death occu	a, and due to the cau urred at the time, date	ise(s) and manner as s o and place, and due to	tated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	dei H.D		29c. Licens		290	d. Date signed (Month,	Day, Year)
			/3			D-005	00949		7/24/01	5
5	1B17		30. Name and address of person who Kamakshi Baig, MI	completed cause of death (I), 6620 Crain	tem 23a) (Type	Print)	LaPlata	MD 20676	,	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Resistrar's Si	maturo	hart a	narrata,	בעוז 20046		
	Pogieti	25	JUL 2 7 1	2005	. K .	Tanal B				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 19b per fh 8846 8-10-05 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Month Physician LINDA C. GRAFTON 3, August 2005 4:55PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3232 Scarboro Road Harford Street If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 Tr Yrs. 11/30/1956 48 Director 212-70-8233 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show tre Medical Examinar must be notified at MD . 1 ☐ Yes 2 ☑ No Harford Street Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3232 Scarboro Road 21154 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: Completed by Specify 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumetic event, tre Ms. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Church 17. Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Seitz 2nd Sue Kinhart Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Alfing Eddre Edic green Reducation via 1 & ity opAwn. 9a7 3107 code)
Lanking Funeral Talle, inc., inc. Main St., ielia, FA 1314 William Grafton/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Highview Memorial Gardns 8/8/2005 Fallston, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Funeral Service Licenses 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imprediate Cause (Final disease or condition resulting in death) renal Physician cell Calcinoma mon lles /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760 phy as nse IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ₫ in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. P 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No page certificate 1 ☐ Yes Division of Vital 2 X No the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide hours after within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date, signed (Month, Dey, Year) 11848 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B BALTU MYU

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month Day, Year)

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gistrar's Signature

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			1 - For State Registrar	State of M	Maryland / De	partment <i>ertificate</i>			ind M	,	giene	000	2622	Ļ
	Physici /Medic		1. Decedent's Name (First, Middle, Rose Mary Hebb	Last)						2. Date of De Month	Day	Year	3. Time of Do	eath M
	Examir		4a. Facility Name (If not institution,	-	•	4b. City, To	own, or L	ocation of				County of Dea	th	
			13538 Paradise			Hage:			14 11			shingto		
	Funeral Director		5. Social Security Number 217–42–9695 Usual Residence of Decedent	6. Sex 7 1 ☐ M 2 X F	Age (In yrs. last birtho	Months		If Under 2 Hours	Min.	8. Date of Bi (Month, Da 8/05/1	th 19, Year) 945		thplace (State or Fountry) (erstown	Foreign
	the Maryland 28a-f show outfied at	ector	10a. State 10b. County Maryland Washin; 10e. Street and Number	gton	10c. City, Town of	own					40.00		10d. Inside City	
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21215-0036	vithin 72 h ne. han "natu e Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4c	or 5+)	ecedent's Usual live kind of work ie. DO NOT use maker	Occupati done du retired)	ion Iring most	of working	g		ind of Business	Industry	
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Baltimore,	Pages 1 and 3 nent of Health ant: If Item 27 ary or other tra		20a. Method of Disposition Burial 2 Cremation 4 Donation 5 Other (Sp.	3 □Removal from Sta	20b. Place of D	8 Parad: sposition (Name crematory or oth en Cemet	of er place)	}	D	надел : 3 200	20c. Lo	m, Md 2 cation - City or lagersto	Town, State	_
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service L	<		22. Name and Rest Hav	zen '	Funer	-a1 (Chapel				
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			State of Maryland / De 23a-b,pt.II,27,28a	eriincale oi Dealii		NOCUUS 2622
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Exan	iner	DOCTORS COMMUNIT	· ·	4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGES
Funer	al	Social Security Number 6. S	Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Fr
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the Mi	Director	MD. PRINCE G	GEORGES	CHEVERLY	10-	1 X Yes 2[
with as or	Dir		TT.	10f. Zip Code	100	. Citizen of What Country?
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year James Dale Hastings J6 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NICOMICO -54/15h111 TENINSHIP If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day,) 11–14–38 Birthplace (State or Foreign Country) **Funeral** Year) Days Hours X□M 2□F 217-36-2137 Director 66 Md. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director Sharptown Wicomico Md. 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 21861 P.O.Box 358 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ð Specify 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry repernit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than "na any injury or other traumatic event. The Majic once. Elementary/Secondary (0-12) College (1-4or 5+) Nylon Co. Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nettie James James C. Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12066 Laurel Rd. Mardela Springs, Md. 21837 Robert J. Hastings, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State *4 □ Donation 5 □ Other (Specify) Fireman's Cemetery 7-29-05 Sharptown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home 700 W. St. Laurel, De. 19956 23a. Pert1. Per thi disease, secomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high failure. List of this ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemic /Medical Due to (or as a consequence of): Examiner Interction In the sol Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) should be detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 □ Yes 2 □ 1/0 peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 241 No 1 Yes 2 No 1 Yes or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 **N**o 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 ortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1501001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEague SAlisbury WD 1002 Carrell Shoet 31. Date filed (Month, JUL 2 8 2005 32. Figistrar's Signature State Registrar

Lee Holloway

			Please Type or Print in Black Indelible Ink. Ensure All	I Copies	Are Legible.	
	117		State of Maryland / Department of Health and M		•	
ш			1- State Registrar Amended item #9 per fh/wich@grtificate of Death 7-28 1. Decedent's Name (First, Middle, Last)	-05/d1s		26227
	Physici /Medio		LEE FRANCIS HOLLOWAY, JR.	Month	a a a a a a a a a a a a a a a a a a a	5 1547M
	Examin		4a. Facility Name (If not institution, give street and number) Memorial Hospital 4b. City, Town, or Location of Death EASTON	,	4c. County of Dea	th to
	Funeral Director		5. Social Security Number 219-03-0538 6. Sex 7 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min M	8. Date of Birt (Month, Day ARCH 2	9. Bir Y. Year) 9. Bir 2. 1916	thplace (State or Foreign ountry)
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Maryli la-f sho	ctor	DELAWARE SUSSEX SEAFORD			1 □Yes 2MNo
	death with the Maryland ims 23a or 28a-f show	al Directo	106. Street and Number 9828 NANTICOKE CIRCLE 107. Zip Code 19973		10g. Citizen of What C	
5-0036	be filed within 72 hours after death with the Marylan it all tygiene. Identifysiene. Identifysiene. Identifysiene. Instrument be notified.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto for It Yes, Specify: 1 Never Married 2 Married 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto for It Yes, Specify: 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Specify: It Yes, Specify Cuban, Mexican, Puerto for It Yes, Specify: It Yes, Specify: It Yes 2 No Specify:	ecify Yes or No- Rican, etc.)		
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lary	ges 1 and 2 should be it of Health and Mental it item 27 is marked or or other traumatic eve		19a. Informant's Name/Relationship (Type, Print) AUGHTER 19b. Mailing Address (Street and Number or Rura	l Route Numbe	er, City or Town, State,	Zip Code)
€	1 and Health Bm 27 ther t		SHARON H. SPENCER 7659 GRACE CIRCLE 3 20a. Method of Disposition 20b. Place of Disposition (Name of	SEAFOR	D. DELAWAI 20c. Location - City or	
_	Pages ment of h ant: If it ury or o	3	1 Deurial 2 Cremation 3 Removal from State CONCORD at METHODIST 7/29 1 Donation 5 Oher (Specify) CEMETERY			, MARYLAND
pall	permit. Pages Department of Important: If i any injury or once.		21. Signature of was service Licente WATESON MORE ANTIECS FUN SEAFORD, DELAWAR			•
			234. Part 1. Emer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition as H			Onset and Death
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VItal	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No			
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	ie Hospi 24 hou ie Funer iletely fill	edical	29a. Certifier (Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, o	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifies 29c. License number	-	29d. Date signed (Mont	h, Day, Year)
	803		30. Na rid addres of person, o compl. ted cause of death (Item 23a) (Type, Print)	5	July 23	2005
	12/2	3	Faith MATZONE 29 J. WAShindon & EASTM. M	ND.	04	
H	Sta Registr		29b. Signature and title of certifies 29c. License number H005377 30. Na ind addres of person o completed cause of death (Item 23a) (Type, Print) Faith MATZONT 29c. License number H005377 31. Date filed (Month, Day, Year) 32. Posistrar's Signature 33. Posistrar's Signature			

Registrar DHMH 17 Rev 1/2001

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111 PENN STREET, BALTIMORE, MD

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

LOCKE

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** HUSKEY KATHLEEN GOSNELL 1:55 A M JULY24, 2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CARROLL WESTMINSTER WESTMINSTER NURSING HOME If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 F 214-40-6320 Yrs. Director 7/9/1914 MARYLAND Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 □ No ŏ CARROLL WESTMINSTER MD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 173 W. MAIN ST. USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE þ ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0·12) College (1-4or 5+) 12 NURSE HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ages 1 and 2 should be fill not of Health and Mental His marked of Be DORSEY TOLLY BURTON GOSNELL MABEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROBERT G. HUSKEY - SON 3042 PUTTY HILL RD., BALTIMORE, MD. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Ites
any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) WESTMINSTER CEMETERY 7/27/05 WESTMINSTER, MD. 21. Ignatura o Esperal Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician MYCCAZIAL ACUTE INFAROTTON SUDDEN /Medical Due to (or as a consequence of): Examiner VASULAL DISCASE CORONIZZ DETERIOSCUEROTIC Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed HYERTENSION YEARS Due to (or as a consequence of): attending physicien Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 Yes No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No ISTEO POROSIS or Attending Physicien: after death. Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Division of Vital Records, To the Hospitel within 24 hours a To the Funerel (completely filled MZZ 445

Baltimore, Maryland 21215-0036

Box 68760

P.O. |

State Registrar

29b. Signature and title of certifier

904 WASHWOOD ED WESTMUSTER MD 2115 SETHUR L. BUDO, M.D. 32. Redistrar's Signature 31. Date filed (Month, Day, Year) JUL 2 6 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

ATTENDING PHYSICHU

29c. License number

121155

29d. Date signed (Month, Day, Year)

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	Physici		Maria		Hixon	Aug		2 2005	4:45	Ам
	/Medio Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc	cation of Death		4c. County of Death		
1			20921 Lehman Mill Road		Hagerstow			Washingt	on	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (Ir 1 M 2 F 7.	yrs. last birthday) Yrs.		7-9	e of Birth onth, Day, Ye ~1932	9. Birth Cou Germa		or Foreign
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	286-1	rect	10e. Street and Number	igerscown	10f. Zip Code		10g.	Citizen of What Cou	ntry?	
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Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee		2. Name and Address of					
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	Hospitei 24 hours a Funerel I tely filled	Medical Ce	29a. Certifier (Check only opportunity) (Check	amination and/or in						s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1 h	29c. License nu	(5.2.)	29d.	Date signed (Month,	Day, Year)	25
	2		30 Ime and address of person who combleted cause of death	(Item 231) (Type,	Print)		1	1	10	
G	2		Frederic 17 KASS III	m1) 1	1110 m	chiel (mou	1 fel	Just	rito
1	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	W	1 (0.000	itam.	had	
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Mary Marguerite Hesson 2005 06:10 A August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 18006 Sand Wedge Drive Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 200 F Yrs. 76 Director <u>212-24-7130</u> 06/26/1929 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 18006 Sand Wedge Drive US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e tiled within at Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) 0wner Restaurant mit. Pages 1 and 2 should be tiled w partment of Health and Mental Hygien portant: If Item 27 Is marked other tilly injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Kate Unklesbee Harvey Clinton Cline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond A. Potts Jr. / Son 1147 Moulstown Road, Hanover, PA 17331 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Leitersburg Cemetery 08/04/2005 | Leitersburg, MD * 4 ☐ Donation 5 ☐ Other (Specify) Departi Departi Importi any inj 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service License 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician UIVG /Medical Examiner Sequentially list conditions, if any, leading to immediate the sequence of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 1 No 3 Probably 4 Unknown 1 Tes Completed need 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has linector, page 2 s autopsy perform 1 Yes 2 **□** No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. М 2 Accident illed in by the after deat Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely tilled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ti 0022043 who completed cause of death (Item 23a) (Type, Print) 11110 Medical Campus Road #130, Hagerstown, MD 21742 Dwight L. Wooster, 44-4 31. Date filed (Month Day Year) 2 32. Rigistrar's Signature State 2005 Registrar

			_ FOI	partment of Health and Mo		ne 2005 26232
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medic		Thelma T. Holloway			Day 2005 11:30P M
	Examin	er	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park		4c. County of Death Iontgomery
	Funeral Director		5. Social Security Number 579-34-5812 6. Sex 1 \square M 2 \square F 7. Age (In yrs. last birthday 76 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea April 21	9. Birthplace (State or Foreign Country) 1929 Wash., DC
	ō		Usual Residence of Decedent		APITI ZI	
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or liems 23a or 28a-f show event, the Madical Exart and the Indiffical at	ō	10a. State			10d. Inside City Limits 12 Yes 2 □ No
	28a-f	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th with		2213 Gaylord Drive	20746	Ur	nited States
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
330	within 72 hours after ene. then "naturel", or Ite	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ No If Yes, Give 9	1 ☐ Yes 2 ☒ No Specify:		Specify: Black
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ם ע	Hygie other	Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	*
yland		To B	Scott Collins	Sarah E		
Mar	ges 1 and 2 should tof Health and Mer If item 27 Is marke or other treumatic		19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) 19b. Mai 133	iling Address <i>(Street and Number or Rural</i> 10 Trumpeter Swa	Route Number, Cit	y or Town, State, Zip Code)
a)	Health tem 27 other tr		Johnnie D. Hollway Jr/son Upp 20a. Method of Disposition 20b. Place of Disp	er Marlboro, Mar position (Name of ematory or other place)		U / / 4 Location - City or Town, State
ō E	Pages nent of int: If it iry or o			ection Cem. 7/28/	/05 Cl	inton, Md.
Baitimor	permit. Pages Department of Importent: If i any injury or once.			22. Name and Address of Facility Hoc 910 Silver Hill		
			23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	r respirat rrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition a	is hulmonary	Jail	UCC Chisal and Dealin
	Examiner		Due to (or as a conseque of):	woo operated	$\frac{1}{2}$	
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a Carpent	1	
	and I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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٥	artificat ing phy e as th	Medi	IF FEMALE:			
gox	leath certific attending p I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
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ds, r	requires that the de een signed by the a nould be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Duknown
ecord	> 9 70	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
T	The ate h page	Com			performed	? death?
VITai	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		
O	Phys er this eral dii	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c, Injury at 2	ne 5 🗌 Residence 28d. Describe how in	6 ☐ Other (Specify)
<u> </u>	Attending F death. ctor: After y the funer	atio	2 Accident investigation	Work? M 1 □ Yes 2 □ No		
DIVISION	after de l'Directed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 2	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause ed at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier	29c. License number	29d. l	Date signed (Month, Day, Year)
	12			5614-	7	(123/0)
*			30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Dpinder Singh, 14300 Galen	e,Print) t Fox Lane, Bowi	e, Md. :	20715
	Sta		31. Date filed (Month, Day, Year) /32. Registrar's Signature		,	
	Registi	rar	JUL 2 7 2005 Keeker A James	Mar.		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 9:00 A M 23, 2005 July JOHN ARTHUR HUMBERT, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel 499 Maple Ridge Road Odenton If Under 1 Year Months Days 6. Sex 1 ፟ M 2 ☐ F If Under 24 Hrs. 8. Date of Birth (Month, Day, May 22, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Pennsylvania 65 Yrs Director 171-32-7692 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Experiment has be notified at 1 ☐ Yes 2 X No Directo Maryland Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 U.S.A. 499 Maple Ridge Road 21113 by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Government Printing Office Bookbinder 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Oppartment of Health and Mental Hy Important: if Itam 27 is marked other any injury or other traumatic event <u>once</u>. Be Gretchen Ellen Wagner John Arthur Humbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 499 Maple Ridge Road, Odenton, Maryland 21113 Jeanne Ellaine Humbert - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 Cremation 3 ☐ Removal from State 7/29/2005 Alexandria, Virginia Metropolitan Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service/Liberal 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Sudden Cardiac Death /Medical Due to (or as a consequence of): **Examiner** Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Hypertension that initiated events nding physician and resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Coronary Artery Disease use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an certificate 1

▼ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 XYes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Natural 2 ☐ Accident Injury 5 Pending 1 Yes 2 No death. investigation within 24 hours after deat To the Funaral Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 29a. Certifier 1 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D46998 July 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven T. Tee, MD 3415 Hamilton Street, Hyattsville, Maryland 20782-5167 31. Date filed (Month, Day, Year) Registrar 2005

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. N2 0 0 5 2	6234
	Physici /Medic Examir Funeral	cal	1. Decedent's Name (First, Middle, Last) Andrew T. Jackson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death White Security Number 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (In yrs. last birthday)	Time of Death Grant M (State or Foreign
	Director		077-32-6573 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. In Autgust 10d. In Autgust 10d. In Autgust 10d. In Autgust 10d. In Autgust 10d. In Autgust 10d. In Ind. Ind.	nside City Limits
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Manfal Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, II a Madical Examinationustic event, II a Madical Examinationustics notified at	Completed by Funeral Director	District of Columbia Washington 10e. Street and Number 4407 Hayes Street, NE 11. Marital Status 11. Never Married 2 Married 3 Widowed 4 \(\beta \) Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\beta \) Yes 2 \(\beta \) No \(\beta \) In \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify: 1 \(\beta \) Specify:	dian,
21215-0036	d within 72 hogiene. giene. er then "natu	completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 years 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Mechanic 16b. Kind of Business/Industry (Sive kind of working life. DO NOT use retired) Self Employ	
Maryland	2 should be filed and Mental Hygie Is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	9)
	1 and 2 s Health ar em 27 ls ther trau		Jean E. Caraway - Friend 4407 Hayes St., NE Washington, DC 20019 20a Method of Disposition (Name of Disposition	
Baltimore,	Page nent o ant: If ary or		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lee's Crematory 7/26/2005 Clinton, M	
Ba	permit. Departr Importa any inju		22. Name and Address of Facility Stewart Funeral Home 4001 benning Rd., N.E. Wash., DC 2001: 23a. Part1 - First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Appr	9
760,	w requires that the death certificate be executed x X We described been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	shoot, a heart failure. List only one cause on each line. Immediate Cause (Final disease or application resulting in death) Sequentially list conditions, I any board to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last List only one cause are consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	roximate rval Between et and Death
.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph age 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Year
<u>α</u>	equires that en signed b			use of death?
al Records,	The lay ate has page 2	Completed		ion of cause of
Division of Vital	Attending Physician: r death. ector: After this certific. by the funeral director,	ation; To Be	examiner? 1 Yes 2 No	
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:		te Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated.	
	To T To 1	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, V 40053927 Tuly 21, 22	Year)
<u></u>	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Status or Sylvator, 301 Hospital Drine, Chrely, May I May	d
	Sta Regist		31. Date filed (Month, Day, Vear) 22. Registrar's Signature	

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend items 2,24a per doc 8846 8-10-09 Vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. 2.00 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** one 2338 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and nymber) 4b. City, Town, or Location of Death Examiner Baltimore Miversil hoch /am au If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Yrs. 215-16-3390 82 APRIL 15,1923 MARYLAND **Director** Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 XYes 2 □ No Director CAROLINE GREENSBORO MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21639 DUTCHMAN'S LANE 424 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STORE CLERK RETAIL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be and Mental JANIE GARDNER LAWRENCE QUINN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an Item 27 P.O. BOX 138, HILLSBORO, MD 21641 DANNY E. JONES/ SON 20b. Place of Disposition (Name of Date 20a, Method of Disposition 20c. Location - City or Town, State Department of I Important: If Its any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CHESAPEAKE CREMATION 7-23-2005 STEVENSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) CENTER LLC
22. Name and Address of Facility 21. Sign was of Fune at Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 □ Yes 2 ⊠ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) the a detached þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has 2 No Yes Physician: the luneral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No this 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attanding 5 Pending Injury after death. 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral E 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 15952 7-20-2005 Name and address of person who completed cause of death (Item 23a) (Type, Print) 29 S. Livery inthon 31. Date filed (Month, Day, Year) 32_Registrar's Signature State Registrar

Anend Items 20b, C per III 2046 8-23-5 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene item 8 per inf 8847 Certificate of Death 1 - State Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1356 M JULI OHUSON 21 2005 SAAC /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner TNNAPOliS Arundel Gen. HOSP | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1939 | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | March | 18 1938 | North | Carolina 5 Social Security Number **Funeral** 1X M 2 ☐ F 578-50-2139 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County wode or than "natural", or items 23a or 28a-f ebovers. The Medical Examinar must be inclined at tx☐Yes 2☐No New Carrollton Prince George's MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5462 85th Avenue T-2 20784 U.S.A. Completed by Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Yes 2 [3] No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. **Black** 3 Widowed 4 Divorced 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than Government Steam Engineer 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pannie Mae Kornegay markad James .Iohnson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5462 85th Avenue T-2 New Carrollton, Maryland 20784 Johnson/Wife Betty Mae Health em 27 item 2 20c Lecation - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Resurrection Cemetery, 7/30/05 Department of H important: if ite any injury or ot once. 1

Burial 2 □ Cremation 3 □ Removal from State -Landover, Maryland 4 Donation 5 Other (Specify) J. B. Jenkins Funeral Home Signature of Funeral Pervice Coensee 22. Name and Address of Facility 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line. Approximate Onset and Death Immediate Cause (Final Interioscienotic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to initive diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quality for as a nonsequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 3 ☐ Probably 4 ☑ Vnknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No 2 2 No this certificate or Attending Physician: After this certification 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 NER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation s effer dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier com eted cause of death (Item 23a) (Type, Print) Nes, MD Registrar's Signature 31. Date filed (Month, Day, Year) JUL 2 7 2005

Registrar

05-04861 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene INK 1 - For State Registra Reg. No.2005 Certificate of Death Ja'na Jones 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Ja'na Jones July 18, 2005 12:24 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20 High Seas Court Baltimore Essex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2\XF Director 215-33-0078 June 29, 1991 14 Maryland Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Insportant: If item 27 is marked other then "naturel", or items 23a or 28a-f show empiny or other traumatic event, the Medical Examples in must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Essex 1 XYes 2 No Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20 High Seas Court 21221 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White ican 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1□Yes 2⊡No Baltimore, Maryland 21215-0036 þ Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Student None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Johnny Montino Jones Adrian King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adrian Wiley - Mother 1622 Q St., S.E. Wash., DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 7/28/2005 Landover, MD 21. Signature of Furieral Service Licens 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intofication Carbon **Physician** Moroxide /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien end for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of d4 h?

1 X Yes 2□ No 24a. Was an cete has t autopsy performed? 1 Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene 1XYes 2□No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Subject inheld After 1 Natural
2 Accident
3 Suicide 5 Pending carbon monojude 12:15 PM 1 ☐ Yes 2 No investigation Pound 4/18/05 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number, or Rural Route Number, City or Town, State) 20 thing Seas Court 4 | Homicide Gene Essex, MD the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) within 24 To the Fu 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Douthall, mo OCME July 19, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pamela E. bouthan, MD 111 PennStreet, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			State of Maryland / Department of Health and 1- For MEND#1,23aPt1&2perMD7/27/05,DPS MCCO to the Registrar	Mental Hy	giene Rog. N2 0 0 5	26238
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Clinton Lee Jackson Clinton Jackson	2. Date of De Month July 18	Day Yeel	3. Time of Death 3:20 AM
	Examir Funeral	er	4a. Facility Name (If not institution, give street and number) St. Thomas Moore Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr	S. 8. Date of Birl		ath Georges irthplace (State or Foreign
	Director		257-50-3126 Usual Residence of Decedent 10a. State 10b. County Min 2 F 69 Yrs. Months Days Hours Min 10c. City, Town or Location	June 4	,1936 Mi	lledgeville,G/
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28e-f show any injury or other treumatic event, if a Marical Examination will be multilized at 906e.	Funeral Director	DC Washington 10e. Street and Number 10f. Zip Code		10g. Citizen of What 0	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with a or	בַּ	2645 Birney Place SE 20020		United S	
	r death	ınera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No		nerican Indian,
3036	ours afte	by	1 ★ Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:		Specify-	Black
Maryland 21215-0036	ithin 72 h ne. nan "nett	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired)	orking	16b. Kind of Busines	
d 21	filed w Hygier ther th		8th Foreman Construction 17. Father's Name (First, Middle, Last) 18. Mother's Na	ame (First, Middle,	National Maiden Sumame)	Capitol Hou.
ylan	should be and Mental s marked o	To Be	Johnny D. Jackson Annie M	Mae Prest	on	
	Ith and 27 is m		19a. Informant's Name/Relationship (Type, Print) . 19b. Mailing Address (Street and Number or F 2645 Birney Pl. SE #:			
altimore,	of Hea of Hea fitem		20a. Method of Disposition 1 Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	or Town, State
ğ	it. Pag		`4 □Donation 5 □Other (Specify) Harmony Memorial Cem. 7,			Maryland
Ba	permit Depart import any in	l is	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funds 1 August 1 Royster Funds 1 Ro			20011
			23a. Pan F Enter the disease, or complications that eacled the death. Do not enter the mode of dying, such as cardia shock, or neaft failure. List only one cause on each line.	ac or respiratory a	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cayse (Final disease or condition resulting in death) a. Multiorgan Failure Due to (or as a consequence of):			Weeks
	Examiner		Cirrhogia of Liver			
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. CILTITIOSIS OF LITVEI Due to (or as a consequence of): cause (Disease or injury that initiated events c.			
8760,	icate be executed physician and s the burial-transil	dical Ex	resulting in death) Last Due to (or as a consequence of): d.			
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		23d. Date of d Month	elivery Day Year
	juires that I n signed by Ild be deta	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Encephalopathy, Cirrhosis Liver, Chronic Renal Fai			to the cause of death? Probably 4 □Unknown
I Records,	The law require ate has been si page 2 should t	Completed		24a. Was autor perfo 1 \sum Yes	ssy prior to rmed? death?	autopsy findings available completion of cause of
/ita	ician: Th certificate rector, pag	Be C	examiner?	eath (Check only o		
o	Physi or this o); To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 Other (Sp	ecify)
sion	anding lath.	ation	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
Division of Vital	or Attences after death	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Number or F m, State)	Rural Route Number,
	To the Hospitel or Attending Physician: The lawfin 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred and manner stated.	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
		Me	29b. Signature and trile of certifier 29c. License number	9	29d. Date signed (Mor	_
•	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1 22	
	Sta	ite_	Raman Tuli, M.D. 3503 Perry Street Mt. Rainier, MD 2 31. Date (iled (Month, Day, Year) 32. Begistrar's Signature	20712		
	Regist	ar	31. Date filed (Month, Day, Year) 32. Segistrar's Signature JUL 2 7 2005 32. Segistrar's Signature			

	1	For State Registrar	State of Maryland / [lealth and M	•	2005 26230
Physician /Medica Examiner	1	1. Decedent's Name (First, Middle, Last) Lois Eisentrout Jackso 4a. Facility Name (If not institution, give s		4b. City, Town, o	r Location of Death	2. Date of Death Month	3. Time of Death C. County of Death
Funeral Director		5. Social Security Number 6. Sex 218-30-2319 Usual Residence of Decedent	alfr	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 15-Apr-1926	r) 9-Birthplace (State or Foreign Country) Maryland
he Maryland (186-1 show		10a. State 10b. County Maryland Allegany		3			10d. Inside City Limits 1 □ Yes 2 N No
th with t	a Di	10e. Street and Number 11005 Wel	sh Hill Road, SW	10f. Zip Code 21532-		U.S	Citizen of What Country?
iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, the Medical Extern har routibe inclified at To Bac Completed by Euraral Director	by runer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces2 1	13. Was Decedent of Hif Yes, specify Cuba		cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
d within 72 hours aff giene. er than "natural", or the Medical Exam	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	pation during most of workii d)	ng	Kind of Business/Industry
d 2 should be filed with the and Mental Hygiene. It is marked other that traumatic event, the A	lo Be Co	12 2 17. Father's Name (First, Middle, Last) Edward Eisentrout	nu	190	18. Mother's Name	(First, Middle, Maide	
and 2 sho saith and 1 n 27 is ma er trauma		19a. Informant's Name/Relationship (Type Kim Jackson		. Mailing Address <i>(Street</i> 007 Blan Avon R			or Town, State, Zip Code) Maryland 21543
Dallingte, IV bermit. Pages 1 and Department of Health mportant: If item 27 any injury or other tr		20a. Method of Disposition 1 Burial 2 MiCremation 3 R 4 Donation 5 Other (Specify)	BINOVALITORII STATE	Disposition (Name of ry, crematory or other place and Crematory	ce) D	ate 20c.	Location - City or Town, State
permit. Pages Depertment of Important: If if any injury or once.		21. Signature of Funeral Service License	Wint	22. Name and Addre		ost Ave , Fro	ostburg, MD 21532
Physician /Medical Examiner		23a. Pa . Enter the disease, or complined, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do e cause on each line. Due to (or as a consequence	2 BULMO		r respiratory arrest,	Approximate Interval Between Onset and Death Mww \$ 475
te be executed sysician and be burial-transit	ical EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence				
The law requires that the death certificate be extended to the attending physician cage 2 should be detached for use as the burian cage.	Pnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у		23d. Date of delivery Month Day Year
signed b	2	Part II. Other significant conditions con		n the underlying cause gr	ven in Part I.	23e. Did tobacco	ouse contribute to the cause of death?
The law requires t	Completed					24a. Was an autopsy performed? 1 ☐ Yes 216.	24b. Were autopsy findings available prior to completion of cause of death?
Physician: T this certificate ral director, pa	o Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	ospital:	4	26. Place of Death		2.500
After fune	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. te of Injury (Month, Day Year) 28b.	Time of 28c. Injury Wo		ne 5 Hesidence 28d. Describe how in	6 □Other (Specify) jury occurred
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)			City or Town, Sta	·
the Hospitel or nin 24 hours afte the Funeral Dir npletely filled in	edical	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my knowledge ner: On the basis of examination are and manner stated.	e, death occurred at the ti nd/or investigation, in my o	me, date and place, a opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
F ₹ F 8	Me	29b. Signature and title of certifier		29c. Licens			Date signed (Month, Day, Year)
20		30 Name and address of person who co	impleted cause of death (Item 23a)	(Type, Print)	907 RA D.	mherla	nd, Md. 21502
nas		31. Date filed (Month Day, Year)	32. Agigistrar's Signature	ch warsh	1110	CALL OCT MC	,, 50

			-	State of Maryland	d / De	partment of He	alth and M	ental Hygie	ene	
			1 - For State Registrar	,		ertificate of D			2005	26240
	15.3	*	Decedent's Name (First, Middle, Last)	-				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Freeman L.	Jones				07 2	200	
	Examin		4a. Facility Name (If not institution, give st	. 6		4b. City, Town, or L			4c. County of Dea	
			Ancharage Nursing 5. Social Security Number 6. Sex		and beinglands	Salistan If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Wicomia	rthplace (State or Foreign
	Funeral Director			M 2 F 7. Age (In yrs. la	Yrs.	Months Days	Hours Min.	(Month, Day, Y	ear)	ountry)
			Usuel Residence of Decedent	0						
	nylan how	_	10a. State 10b. County	10c. City						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	ecto	MD WICOM.	160 1	51V	ALVE		100	. Citizen of What C	
-	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or terms 23a or 28a-f ahow event, the Madical Examinar must be notified at	Funeral Director	10e. Street and Number 3399 TEXAS	RD		10f. Zip Code	4	109	USA	ourity :
	death	era		2. Was Decedent Ever in U.S	S. 1	Was Decedent of His If Yes, specify Cuban,		cify Yes or No-	14. Race - Am	
_	or ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 (\$1.0) If Yes, Give		If Yes, specify Cuban,	Specify:	Hican, etc.)	Black, Whi	ite, etc.
250	filed within 72 hours after Hygiene. other than "natural", or Ite ant, the Madical Examine	d by	3 Widowed 4 Divorced	Year or Dates:		***************************************				<u></u>
<u>.</u>	n 72 h	Completed	15. Decedent's Educi (Specify only highest grade	ation completed)	(G	cedent's Usual Occupat ive kind of work done du e. DO NOT use retired)	ion iring most of worki	ng 16	b. Kind of Business	s/Industry
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and	e filed I Hyg other	a a	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma		
<u>a</u>	Mental Mental arked atto ev	To B	DENNIS FRANKI	IN JOHES			MARY	ANN	SONM	KY
Mar	2 sho and is m		19a. Informant's Name/Relationship (Typ			ailing Address (Street an				
	1 and Health In 27		CHRY SONES (20a. Method of Disposition			SOX 3104 1 sposition (Name of			c. Location - City o	
	ages nt of h :: If ite		1 D Surial 2 ☐ Cremation 3 ☐ Re	emoval from State	metery, o	crematory or other place,)		WALVEY	
saitimore,	artme ortani injury		* 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenser		2150	22. Name and Address	of Facility	103 13	10 BUCL	1120
ñ	permit. Pages 1 and 2 should b Department of Health and Meniz Important: If Item 27 is marked any injury or other traumatic e ance.		1 C& Jang Trose	/	6	22. Name and Address MESSICK BLYALYE	Fineral	FINE K	3 100x 101	
0			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death	. Do not					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Rec	to concur				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):			-		3 7 3
	LXailillei	<u></u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):					
	pet nsit	Examiner	Cause (Disease or injury	Due to (or as a consequ	once oi).					
,	be executed sician and burial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):					
760,	\$ × 6	cai	L d.							
20	death certificat e attending phy d for use as th	Med	IF FEMALE:						T	
X Q Q	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1☐Live birth 2☐Fetal	death	3 Ectopic pregnancy			23d. Date of de Month	elivery Day Year
o j	the de y the a ached f	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	atn	5 Other (specify)				
J.	that the de ned by the a detached f		Part II. Other significant conditions cont	tributing to death but not resu	lting in th	e underlying cause giver	in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
rds	The law requires that te has been signed b age 2 should be deta	ed by						1 ☐ Yes	2 No 3 P	robably 4 Unknown
Vital Records	aw ren is bee 2 sho	Completed						24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
ž	sician: The law certificate has t irector, page 2 s	mo:						performe	dath?	s 2 No
<u> </u>	ysician: iis certifica director, I	Be	25. Was case referred to medical examiner?					(Check only one)		
0	Physician: r this certific ral director,	ဥ	TIL Fes ZIZINO			tient 3 DOA Other	4 Mursing Ho		ce 6 ☐Other (Spe	ecify)
	e fe	lon	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Tim Inju	ry Work?	es 2 No	28d. Describe how	injury occurred	
DIVISION	a a a	fical	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm,					Rural Route Number,
2	al or / s after il Dire	Certification:	4 Homicide determined	building, etc. (Specify)			City or Town, S	State)	
	ospit. hours unera ily fille		29a. Certifier 1 Certifying Phys	sician: To the best of my knowner: On the basis of examinat	wledge, d	eath occurred at the time	a, date and place,	and due to the caus	se(s) and manner a	as stated.
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical	one)	and manner stated.	.s., arroy 0					
	5 × 5 8	2	29b. Signature and title of certifier			29c. License			Date signed (Mon	
	23		30. Name and address of person who cor	moleted cause of death fite-	23a\ /T		51359	Ju	dy 26/1	2005
	2	-	DR-USHA NATISAN				LISBURY		4	
	* Sta		31. Date filed (Month, Day, Year)	32. Pigistrar's Signat	ure	South &				
	Pogiati		4	Market Control	110	TIMES SELL				

			State of Maryland / Department	artment of Health and N		2000	2621.1			
			Registrar 1. Decedent's Name (First, Middle, Last)	tineate of Death	Reg. I	<u></u> 0 0 0	3. Time of Death			
	Physicia		Wayne Milton Kellam		July 18,	2005	1303 ^M			
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat				
			Carroll Hospital Center	Westminster		Carroll				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 112 M 2 □ F	if Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	ar) 9. Birt	hplace (State or Foreign			
	Director		216-38-4755 Two Park Park Park Park Park Park Park Park		Oct 2, 19	940 Ma	ryland			
	iand ow		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits			
	Mary F-f sh	ţō	Maryland Carroll Manches	ter			1 ☐ Yes 2 X No			
	h the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	puntry?			
	23a c		2733 Bachman Rd.	21102		USA				
	tams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerlo	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White				
5	72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show ofted Examities in ust be neithed at	by Fi	1 ☐ Never Married 2√2 Married 1√2 Yes 2 ☐ No If Yes, Give Year or Dates: 1Q5Q	1 ☐ Yes 2 ☑ No Specify:		Specify:	hite			
0500-c	tural	edt	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b	. Kind of Business/				
0	within 72 ene. than "ne	plet	(Specify only highest grade completed) (Give life. Elementary/Secondary (0-12) College (1-4or 5+)	n kind of work done during most of wor DO NOT use retired)	king Ba	altimore	County			
7	d with giene er tha	Completed		e Lieutenant	Po	Police Department				
and	be filed tal Hygid d other avant, I	Be (17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	·				
<u>X</u>	should by	မ	Lewellyn W. Kellam		ette Linden					
Mai			10,576,651	ng Address (Street and Number or Ru	at the an executive		Zip Code)			
a)	is 1 and 2 of Health itam 27 i		20a Method of Disposition 20b. Place of Dispo	osition (Name of	hester, MI Date 20c.	21102 Location - City or	Town, State			
	Pages nent of int; If it		**Seurial 2 Cremation 3 Removal from State cemetery, cre 4 Donation 5 Other (Specify)	matory or other place) Cemetery 7/22	2/05 Pa	rkville.	Maryland			
апшо	- 독면구			O Name and Address of Facility						
ă	permi Depar Impor any ir			Pri 12 Washington Rd.			Chapel, PA			
	6 J. (6)		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	almonory Eml	00 (45		Minutes			
	/Medical Examiner		resulting in death) Due to (or as a consequence of):							
	LAGIIIIIEI	Ļ	Sequentially list conditions, if any Leading to immediate b. Due to (or as a consequence of):							
	ted nsit	nine	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury							
,	execunand and ial-tra	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):							
2/00	death certificate be executed e attending physician and nd for use as the burial-transit	cal	d							
Õ	rtifical ng ph as th	ed	DE FEMALE.				-			
X Q Q	ath ce ttendii or use	an/I		Ectopic pregnancy		23d. Date of del	ivery Day Year			
2	es that the death certific igned by the attending p be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 [Other (specify)	· · · · · · · · · · · · · · · · · · ·					
7.	that the ed by th detache		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?			
as,	uires sign ld be	d by			1 ☐ Yes	2 No 3 Pr	obably 4 Unknown			
ecords	law requires as been sign 2 should be	lete			24a. Was an	24b. Were au	utopsy findings available completion of cause of			
T	9 2 9	Completed			autopsy performed	? death?	completion of cause of 2□ No			
VII	i cian: Th certificate rector, pag	Be C	25. Was case referred to medical	26. Place of Dea	ath (Check only one)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
0	dis ys	70 5	examiner? Hospital: 1 Inpatient 2 ER/Outpatie		lome 5 🗌 Residence	6 □Other (Spe	cify)			
	ng fter	on:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	Work?	28d. Describe how in	njury occurred				
<u> </u>	Attanding or death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined to be determined. 28e. Place of Injury - At home, farm, st	M 1 Yes 2 No	28f. Location (Street	and Number or Pi	iral Route Number			
UIVISION	i Dirte	Certification;	4 Homicide determined building, etc. (Specify)	reet, raciory, office	City or Town, St		arar riodio ridinaor,			
	spita nours naral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal							
	To the Hospital within 24 hours a forthe Funaral I completely filled	edical	(Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)			
	To tl	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Mont.				
	INSL		MTI: 11	20051924	3	ely 1812	005			
	13		30. Name and adores of person who completed cause of death (Item 23a) (Type Herbert D. Henderson Jr. M. 2973 Mac	rchester Rd Man	ichester M	0 2110	2			
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature			, , , , ,				
	Registr	ar	JUL 2 1 2005 Kleen &	bert						

DHMH 17 Rev 1/2001

ORIGINAL

		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrer Certificate of Death Reg. 2005 25242											
ì	Physicia		1. Decedent's Name (First, Middle, Last) Dr. Kate Kiss	2. Date of Death 3. Time of Death									
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 1026 Main Street	4b. City, Town, or Location of Death Darlington 4c. County of Death Harford									
	Funeral Director		130-66-3395 10 M 2MF 32 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Oct. 24, 1972 Boston, MA									
	aryland show	70	Usual Residence of Decedent										
	with the M e or 28a-f be notifie	Director	10e. Street and Number 77-16 Austin St., Apt. 3-L	10f. Zip Code 10g. Citizen of What Country?									
920	hin 72 hours after death with the Maryland e. "naturel", or items 23e or 28e-f show Medical Examinar must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	Vas Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 X No Specify: 14. Race - American Indian, Black, White, etc. Specify: White									
Maryland 21215-0036	ne e	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of working ONOT use retired) economist financial									
land 2	od it b	To Be C	17. Father's Name (First, Middle, Last) Edmond J. Schneider	18. Mother's Name (First, Middle, Maiden Sumame) Elaine Callahan									
	12 P P P P P P P P P P P P P P P P P P P	-		g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11375 6 Austin St., Apt. 3-L, Forest HillsNY									
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: If item 27 any injury or other tra		4 Donation 5 Other (Specify) Crem	pater Date 20c. Location · City or Town, State 19136 and Philadelphia PA Philadelphia PA Name and Address of Facility Kuzo & Gofus Funeral Home									
Bal	permi Depa Impo any ir		I told That	Kennett Square PA									
	Pnysician /Medical		23a. Part 1. Enter the disease, or complications that cabsed the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Applications as cardiac or respiratory arrest, Interval Between Onset and Death Years									
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):										
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	al Examiner	cause. Enter Underlying Cause (Cleares or in July) that initiated events resulting in death) Last Due to (or as a consequence of):										
9	artificate ing physi e as the l	Medical	IF FEMALE:										
O. Box	that the death certifics ed by the attending ph detached for use as ti	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Live	Ectopic pregnancy 23d. Date of delivery Month Day Year									
rds, P	quires that an signed t utd be det	by	Part II. Other significant conditions contributing to death but not resulting in the unc	aderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?									
Il Record		Completed		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No									
Vital	Physicien: The l this certificate ha ral director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check only one) 1 3 DOA Other: 4 Nursing Home 5 the esidence 6 Other (Specify)									
ion of	nding Phys th. r: After this e funeral di	ation: To	27. Magner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No									
Division	al or Attendi s after death. Il Director: A ed in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)	eet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inventors and manner stated.	occurred at the time, date and place, and due to the cause(s) and manner as stated, vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
	To t To t	Z	29b. Signature and title of certifier Way Jackson, MD	29c. License number 29d. Date signed (Month, Day, Year) 715314 71427, 2005									
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, F	In thern Clesapeake Hospice, Elkton, 10									
•	Sta Regist		31. Date filed (Month, Day, Year) / 32. Registrar's Signature	park									

			State of Maryland / Department of Health and Certificate of Death	d Mental Hy	giene Reg. Ne	6 3 E 3 V	26243
	•	jst	1. Decedent's Name (First, Middle, Last)	2. Date of Do	aath		3. Time of Death
ı	Physicia /Medic		WILLIAM HOLLINGSWORTH KROUSE	JULY	27	y Year 2005	7.18 a ^M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De-	ath	4c	. County of Dea	
			Frederick Memorial Hospital Frederick		F	rederi	ck
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	in. 8. Date of Bi	rth ay, Year)	9. Bir	thplace (State or Foreign ountry)
	Director		219-34-8299 65	Jan. 1	4,19	40 Was	hington D.C.
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	f sho	ō	Maryland Carroll Mt. Airy				1 ☐ Yes 2 ☑ No
	28a-	Director	10e. Street and Number 10f. Zip Code		10g, Cit	tizen of What C	ountry?
	3a or	ā			Unit	ed Stat	es
	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue			14. Race - Ame	erican Indian,
9	or ite	Fu	Armed Forces? If Yes, specify Cuban, Mexican, Pue 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify:	erio Hican, etc.)		Black, Whi	
<u> </u>	ours Fra	dby	3 ☐ Widowed 4 ♣ Divorced Year or Dates:			Specify: Wh	ıte
, L	72 h natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of w	vorking	16b. K	and of Business	/Industry
2	within ne. hen	dm	Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed		Man	ufactur	ina
2	iled v Hygie ther t nt, in	ပိ	17. Father's Name (First, Middle, Last) 18. Mother's N	lame (First, Middle			Tilg
au	be formulated of the control of the	Be c		n Michael		r oumane)	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. I is marked other then "naturel", or items 23a or 28a-f show reumatic event, the Medical Examiner must be notified at	ို	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I			or Town, State.	Zin Code)
æ ≥	nd 2 s lith ar 27 is r treu		Ernest Steven Krouse/Son 7010 Ridge RD, Freder				
ē,	s 1 ar f Hea item othe		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	*	ocation - City or	
Ë	Page ent o nt: If ry or		1 Burial 2 To remation 3 Removal from State 4 Donation 5 Other (Specify) Frederick Crematory 7/2	29/2005	Fre	derick.	Maryland
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny injury or other treumatic esone.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility S				
m	Per E B		Budley & Smiles 1621 Opossumtown	Pike,Fre	deri	ck, MD	21702
	*		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line.	iac or respiratory a	rrest,		Approximate Interval Between
2	Physician		Immediate Cause (Final disease or condition a. Congestive Heart Fail)	11.0			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):				13
П	Examiner		Sequentially list conditions, b. ASCVD				years
	sit	ine	if any, leading to immediate cause. Enier underlying Cause (Disease or injury				
	and I-tran	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):			-	
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	a E					
687	ficate physis the	edlcal	d.				
Box	death certifica attending phate for use as t	Ž.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	livery
Ď	death e atte d for	icia	in the past 12 months? 1			Month	Day Year
0	that the de led by the a detached t	hys	9 ☐ Unknown				
S,	res tha igned I be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco i	use contribute to	the cause of death?
Srd	w require been sig should b	ted	100m that tobilation	- 10	Yes 2	□No 3750	robably 4 Unknown
Records,	has be	ompleted by Physician/M	Leval Ingustrany	24a. Was		24b. Were at	utopsy findings available completion of cause of
		Con	· · ·	perfe 1 ☐ Yes	ormed?	death?	2 □ No
Vita	icien: Th certificate rector, pag	Be (examiner?	eath (Check only	one)		
	Physi r this c ral dire	2		Home 5 Resi			cify)
–	ling F	lon	27. Manger of Death 1 DNatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injui	ry occurred	
S	death ctor: /	icat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f Location (Stroot an	ad Number or P	ural Route Number,
Division of	after Direct	Certification;	4 Homicide determined building, etc. (Specify)	City or To	wn, State	9)	arai rioute realiber,
_	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier Physician: To the best of my knowledge, death occurred at the time, date and place.	ice, and due to the	cause(s)) and manner as	stated.
	ne Ho n 24 h ne Fu oletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	curred at the time,	date and	d place, and due	to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier 29c. License number	,	29d. Da	te signed (Mont	h, Day, Year)
	3		1 /2 / M/ NO MD 00 55/0	04	7	127/	5
	6		30. Name and address of person who completed duse of death (Item 23a) (Type, Print)	1,61	h	1	21771
				ain st,	Mt.	HIRY	MARYland
•	Sta		31. Date filed (Month, Day, Year) 37. Registrar's Signature			, ,	
	Registr	. 8					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Margare /Medical 4a. Facility Name (If not institution, vive street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. CATHERINE'S NURSING CTR. FREDERICK **EMMITSBURG** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖾 F Yrs. 88 **Director** EMMITSBURG, MD 24,1917 214-32-4807 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Works or items 23a or 28a-f showing at the position at 1 Yes 2 No Director MARYLAND FREDERICK **EMMITSBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 N. SETON AVE. 21727 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: WHITE the Medical Expr 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEKING COLLEGE Pages 1 and 2 should be filed w Iment of Health at a Mental Hygie tant: If item 27 is marked other ti jury or other traumatic event, III 8 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be ANNIE SHORB WILLIAM SHIELDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health alt
Important: If item 27 Is
any injury or other trau 16145 KELABAUGH RD., TONY KELLY, SR. THURMONT, MD. 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 8/9/05 EMMITSBURG, MD. NEW ST. JOSEPH'S 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727-0427 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death medate Cause (Final sease or condition sulfing in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Coverary a Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) the a o 9 Unknown 9 Unknown ed by the Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by sign be 1 Tes 2 No 3 Probably 4 ☑Unknown should should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy perform 2 X No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4

✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 Homicide o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of contil 29d. Date signed (Month, Day, Year) 6 05 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) M.D. 302 W. MAIN ST., EMMITSBURG, MD. 21727 'n. FERGUSON. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Régistrar 2005

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death Reg. No. 2 11 15	26215
			1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day Year	G. Time of Death
	Physici /Medic		Agnes Rita Kanowicz August 1, 2005	8:00 a.m.
	Examir		4b City Town or Location of Death 4c County of Death	1
		Q	Gladys Spellman Nursing Center Cheverly Prince	
À	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) (Month, Day, Year)	nplece (State or Foreign untry)
	Director		170-24-6609 75 TS. Dec. 15, 1929 Pen	nsylvania
	2 2	. }	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
	anyla shor	_		1 ☐ Yes 2 ♣ No
	Ne M	5	Maryland St. Mary's Leonardtown 109. Street end Number 109. Citizen of What Cou	inter?
	with t	늄	106. Street end Number 10f. Zip Code 10g. Citizen of What Cou	•
	234	Funeral Director	22466 Armstrong Drive 20650 United St	
	er de	5	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?) 14. Race - Amer Black, White	
20	rs aft	by F		te
8	n 72 hours after death with the Maryland "natural", or items 23a or 28a-1 show patical Examinet must be notified at	8	15. Decedent's Education 16a. Decedent's Usuel Occupetion 16b. Kind of Business/li	ndustry
15	in 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	
212	filed within Hyglene. ther than "	E	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hom	.e
p	be filed itel Hygi d other event, I	Be C		
<u>a</u>	should be filed nd Mentel Hygi marked other imatic event,	ToB	Stanley Laskoski Mary Valendy	
Maryland 21215-0020			19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z.	ip Code)
	12 H 2		Henry J. Kanowicz / Husband 22466 Armstrong Drive, Leonardtown, MD 2	0650
re	of Heal of Heal r Itam 2 r other	ĺ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To	own, State
Ĕ	Pages nent of int: if Itu		1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) Queen of Peace 8-6-05 Helen, Mary	land
Baltimore,	permit. Page Department of Important: if any injury or once.	Ì	21. Signature Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral H	
ä	P P P P		Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD	
		\Box	23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between
W.	Physician	8	shock, or heart failure. List only one cause on each line.	Onset and Death
-	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Core way and the condition of the condit	(cfr.
1	Examiner		resulting in death) Due to (or as a copsequence of):	
	n #	ner	Dia buta Maldital	20018
	The law requires that the death cartificate be assocuted ta has been signed by the attending physician and page 2 should be detached for use as the buriel-transit	Examiner	Sequentielly list conditions, Due to (or es e consequence of):	
Ö,	a axe	<u> </u>	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	
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Вох	aath ca attendi I for use	an/		
	e dag	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	to the cause of death?
P.0	res that the da signed by the a be datached t			obably 4 thinknown
	igne bed	by		Vere autopsy findings
of Vital Records,	v require been sig should t	Completed	24a. Was an autopsy performed?	vailable prior to completion of cause
ec	has b	du		of death?
H		So	respiratory tailure illyes 21 No 1	☐Yes 2년¶o
/ita	Physician: The rthis certificata	Be	25. Was case referred to madical 26. Place of Death (Check only one)	
=	S 00 D	P	1 Yes 2 1 No Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Notation 4 Notation 5 Residence 6 Other (Spec	ify)
	ng P	ö	27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred North	
Sio	Attanding or death. octor: After by tha fune	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury at home farm street factory office 28f. Location (Street and Number or Ru	
Division	or Att after d Direct I in by	Certification:	28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ru	rai Houte Number,
	To the Hospital or Attending Phwitin 24 hours after death. To the Funeral Director: After thi completaly filled in by the funerel	రి		stated
	Hosp 24 ho Fune fally f	edlcal	29a. Certifier (Check only one) 29a. Medical Examiner: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.	to the cause(s)
	To the Hospital within 24 hours of To the Funeral completely filled	Me.	E 29b. Signature endititle of certifier 29c. License number 29d. Date signed (Month)	n, Day, Yeer)
	₩¥ ¥ ¥ 8		Kalumy 0,6273 MD 8/1	105
		-	30(Nembe and address of Person who completed cause of death (Item 23a) (Type, Print)	
			20 Nems and address or objects of completed cause of death (tem 25a) (17be, Film) do ver 2d, Chevert	750
	Sta	te	31. Date filed (Month, Day, Year) 32. Register's Signature	VX0753
2	510		THIC D A 2005 N As a second of	ļ

State Registrar AUG 02 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** July 29, 2005 5:35 P Kershner Dorene Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 223 Hebb Rd Washington Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🖔 F Director 220-18-1118 78 Nov 21 1926 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Iteme 23a or 28a-f show the Medical Examiner must be neithed at 1 ☐ Yes 2X No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 223 Hebb Rd 21740 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ☐ Yes 2X No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygies Important: If item 27 Is marked other It any injury or other traumatic event, ILLS ODGS. Home Maker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Keckler Bernadette Bowling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9806 Sharpsburg Pike Hagerstown Maryland 21740 David D Kershner / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery | Aug 2, 2005 | Hagerstown Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown MD 21742 23a. Part1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-translt Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physician Completed by Physician/Medical signed by the ettending phys d be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 1 □ Yes 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Z Yes 2 No 3 ☐ Probably 4 ☐Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 | Yes 2 | Hospital: Other: 4 Nursing Home Sesidence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 2 2005 Registrar

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD 111 Penn Street Baltimore, Maryland 21201 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registra

OCME

July 19, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For	State of Maryland / Department of Health and N		AAAM ACALC	2
			1 - State Registrar	Certificate of Death		<u>2005 26249</u>	
	Physic	an	Decedent's Name (First, Middle, Last)	V - 2 - 72	2. Date of Death Month	Day Year 3. Time of Dear	
	/Medi	cal	TATIANA 4a. Facility Name (If not institution, give s	KARCHER treet and number) 4b. City, Town, or Location of Death	7011	Day 2005 05 2 4c. County of Death	
	Examir	ner	C - I No -	es Anspital Baltimore	•	to. County of Beatin	
	Funeral	_	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yei	9. Birthplace (State or For	reign
	Director		NONE	M 200 F Yrs. Months Days Hours Min.	141 30,	2015 Maryan	9
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		10d. Inside City Lir	mits
	Maryla 1 sho	ō	In	Prolimore		1 N Yes 2 □	
	death with the Maryland ms 23a or 28a-f show rmatte notified at	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?	
	h with	al Di	38 South Co	irlton Street 21223	()	rited States	
	ems armu	Funeral	TT. Wantai Olalas	Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Pueno	pecify Yes or No-	14. Race - American Indian, Black, White, etc.	
36	or It	by Fu	Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ Mo Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: D \ = CV	
Ö	hours tural'	q pe	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16h	. Kind of Business/Industry	
7.	in 72 in 72	Completed	(Specify only highest grade	completed) (Give kind of work done during most of work life, DO NOT use retired)	king	, Kind of Business/Industry	
212	d with giene.	mo:	Elementary/Secondary (0-12)	College (1-4or 5+) NEWBORN			
9	al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	den Sumame)	
<u>a</u>	Ments Ments arked atic e	To	Dawayne	Manning Lisa	Harch	795	
Marvland 21215-0036	2 sho		19a. Informant's Name/Reinfonship (Ty)	1000	ral Route Number, Cit	ty or Town, State, Zip Code) MORE, MARY LAN	QD.
			LISA KARCHER/r 20a. Method of Disposition		212	. Location - City or Town, State	
Baltimore.	nt of h		Burial 2 ☐ Cremation 3 ☐ R	moval from State	4.46	TIMORE MARYLAN	00
量	artme ortant injury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	CEMETARY 1, 2	6000		_
ä	permi Depa Impo any ir		I De advantor	grandue Lynn 900 CATON AVENUE	BALTIMOR	RE, MARYLAND 312	29
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. Do not enter the mode of dying, such as cardiac of a cause on each line.	or respiratory arrest,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Extreme prematuri	+11	Onset and Death	
	/Medical		resulting in death)	Due to (or as a consequence of):	, 4	OI WIN	ربير
	Examiner	,	Sequentially list conditions.				
	ted nsit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
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Box	death certific e attending pi d for use as (N/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy		23d. Date of delivery	
m.	p @ 0	icia	in the past 12 months? 1 ☐ Yes 2 No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month Day Year	
ト G	at the by th	Physician/M	9 Unknown	9□ Unknown			
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70	Phy er this	\vdash	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how in	6 ☐Other (Specify) njury occurred	-
8 io	nding ath. r: Afte e fun	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No			
Bab	r Atte er de recto by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)	
0	ital o irs aft ral Di led in	Cer					
	Hosp 4 hou Fune fely fil	ical	(Check only 2 Medical Examin	cien: To the best of my knowledge, death occurred at the time, date and place, er: On the basis of examination and/or investigation, in my opinion, death occurr			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29b. Signature and title of certifier	and manner stated. 29c. License number	29d. C	Date signed (Month, Day, Year)	
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			30. Name and address of person who con	ppleted cause of death (Item 23a) (Type, Print) Sqint Aqn es	Hispital	17 30, 2005	
			- 0 0 - 10 A 10				
			JORGE R. AND	RADE GOOCATON AVENUE Ba	timore	mary and 2122	19

			For State Registrar	State of Maryland	•	artment of Hertificate of L			iene 	26250	
			1. Decedent's Name (First, Middle, Last,					2. Date of Deat	h	3. Time of Death	
	Physicia /Medic		Norman Eugene	Logan				July	24 2005		
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or			4c. County of Dea	th	
		•	Holy Cross Hos 5. Social Security Number 6. Sec		ast hirthday)	Si If Under 1 Year	lver Spr	8. Date of Birth	9 Ri	ntgomery thplace (State or Foreign	
	Funeral Director			XM 2□F 61	Yrs.	Months Days	Hours Min.		Year) C	ash., DC	
	ס		Usual Residence of Decedent					[114]			
	anylan show	_	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits 1 XYes 2 No	
	Se-f	Funeral Director	Maryland Montg	omery			ver Spri		0g. Citizen of What C		
	a or 2	吉	10e. Street and Number	G. #22		10f. Zip Code	20904	"		States	
	ns 23	erai	3502 Pear Tree	12. Was Decedent Ever in U.S	S. 13. 1	Was Decedent of His f Yes, specify Cubar		Specify Yes or No-	14. Race - Am	erican Indian,	
ပ္	after d		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No				to Rican, etc.)		te, etc. rican	
21215-0036	72 hours after death with the Maryland neturel', or items 23a or 28e-1 show Jisal Exammer must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:		Specify: Am	erican	
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d 2	filed Hyg Sther	e Co	12th 17. Father's Name (First, Middle, Last)			Entrep		me (First, Middle, M		ргоуец	
Maryland	2 should be and Mental Is marked o	To B	James E. M						ie B. Loga		
Mar	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Ty Kevin O. Logan	, . ,					City or Town, State, arlboro, M.		
re,	is 1 and 2 of Health a item 27 ls other trai		20a. Method of Disposition	20b. Pl	lace of Dispo	sition (Name of natory or other place	a)	Date	20c. Location - City or	Town, State	
E	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Qonation 5 ☐ Other (Specify)			ion Cemet		29/2005	Clint	on, MD	
Baltimore,	permit. Pages Department of Importent: If i eny injury or once.		21. Signative of Hujeral Service Licens			. Name and Address	s of Facility	Stewart F	uneral Hom		
<u> </u>	89 2 2 3		John 1. 2	leway []					Wash., DC		
	Physician		23a. Part . Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the death ne cause on each line. CARDIAC		er the mode of dying	, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequ						YEARS	
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Box	death certifics e attending ph id for use as t	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year	
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ds,	uires tha signed I Id be det	d by						1 □ Ye	s 2 No 3 P	robably 4 Unknown	
CO	w requir	lete						24a. Was a	n 24b. Were a	utopsy findings available completion of cause of	
Vital Record	The law ate has b page 2 sl	ompleted						autops perform	y prior to ned? death? 2 ⊠No 1 ☐ Yes		
ita		e C	25. Was case referred to medical				26. Place of De	ath (Check only on			
_ \	S S	To B	examiner? 1 ☐ Yes 2 SNo	Hospital: ⊅⊠ Inpatient 2 ☐	ER/Outpatier	it 3□ DOA Othe	1: 4 🗆 Nursing t	Home 5 ☐ Reside	nce 6 Other (Spe	ecify)	
n of			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	?	28d. Describe ho	w injury occurred		
Sio	Attending r death. sctor; After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				/es 2□No	004 Leasting /Ct	mant and Alumbas as II	real Douts Number	
Division	Dir	ertification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, tarm, str	eet, factory, office		City or Town	reet and Number or R i, State)	urai Houle Number,	
	e Hospital or 24 hours afte 8 Funerel Dir etely filled in	edical C		sicien: To the best of my knowner: On the basis of examinat and manner stated.							
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier	4		29c. License	number		9d. Date signed (Mon		
			D. Vilavannad	ty leddy M	٥	D43	3464	J	ULY - 25 - 21	200	
2	6		30. Name and address of person who co	ompleted cause of death (Item BY, III X5 PoukV	23a) (Type,	Print) MCC, SU	TTE 208,	, Rockvi	cue, MA	20852	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 8 2005	Registrar's Signal	tura_	de)					

			For State	State of Mary	land / De	partment of H	lealth and N	/lental Hy	giene		0.66	
			Registrar		C	ertificate of l	Death			005	26251	
	sicia edica	n	Decedent's Name (First, Middle, Last OLDEN	ROSS LANDO	NC			2. Date of De Month July	Day	Year 2005	3. Time of Death 2//J/ M	
	mine	_	4a. Pacility Name (If not institution, give	street and number) U Medical	Center	4b. City, Town, or	Location of Death			Ounty of Death		
Fune Direc			5. Social Security Number 6. Se 228-44-8629		yrs. last birthd. 6 Yrs	Months Days	If Under 24 H/s. Hours Min.	8. Date of Bir (Month, Da JANUARY	th 20, 19	9. Birth Cou VII	nplace (State or Foreign untry) RGINIA	
Aaryland Febow			Usual Residence of Decedent 10a. State 10b. County VIRGINIA ACCOMA		City, Town or						10d. Inside City Limits 1 ☑ Yes 2 □ No	
with the N			10e. Street and Number 4379 LONG BRIDGE		IMMILI	10f. Zip Code 23440			10g. Citize	en of What Cou	untry?	
Lat yiallo Z 12 13-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene and Mental Hygiene "le marked other than "natural", or Items 23e or 28e-1 ehow surner is soon.		by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🌣 Widowed 4 □ Divorced	12. Was Decedent Ever	U.S.	3. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Amer Black, White Specify: WHI	ican Indian, , etc.	
nin 72 hou		Сотріете	15. Decedent's Edu (Specify only highest grad	cation	16a De	cedent's Usual Occupa ive kind of work done on e. DO NOT use retired	ation during most of work ()	ting	16b. Kind	d of Business/l	ndustry	
d with		E	Elementary/Secondary (0-12)	College (1°401 54)		WATERMAN	V			SEAFOOD		
yidilo Ziz		o pe	17. Father's Name (First, Middle, Last) CHARLES COLSON	LANDON			18. Mother's Nam		, Maiden Si NRKS	umame)		
2 sho and h			19a. Informant's Name/Relationship (T)			ailing Address (Street a				Town, State, Z	ip Code)	
and land the alth		-	DARREN LANDON/SON			30 W. RIDGE		ANGIER,				
permit. Pages 1 and 2 should be Department of Health and Menta Important: if lieus 27 le marked and injury or other training for other trainings.			20a. Method of Disposition 1 🎇 Burial 2 □ Cremation 3 □ F 14 □ Donation 5 □ Other (Specify)	Namoval nom State		sposition (Name of crematory or other place MENT CHURCH	08/03			ation - City or T R, VIRGI		
Departition of the post of the	once.		21. Signature of Funeral Service Licens			22. Name and Addres		servic pan	VO DV	nn nen	KSLEY, VA 2342	
Physicia / Medic / Medic / Medic / Physicia purial report	cal _. ner	cai Examiner	23a. Parta Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Little Unidentying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	rtie rsequence of):	Shocke Shocke Leed	g, such as cardiac	or respiratory ai	rrest,		Approximate Interval Between Onset and Death	
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and composate tilling in by the intendent director, page 2 should be deached for use as the burial transit		0	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pro 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23	d. Date of delive	very Day Year	
ries that the signed by		2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							co use contribute to the cause of death?		
nper v need		erec						1 0			bably 4 □Unknown	
s certificate has be	. 1	Completed								prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of	
sicier certificacto		۵	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 ☐ Inpatient	2 ER/Outpa	othe	26. Place of Deat	,		70**	· · · · · · · · · · · · · · · · · · ·	
nding Physicien: The Ith. The Ith. The Ith. The Ithis certificate has	į l	non: 10	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time	e of 28c. Injury Work	at tat tes 2 □ No	28d. Describe h			ry)	
al or Attend after death Director:		Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, pecify)	street, factory, office		28f. Location (5 City or Tox	Street and f vn, State)	Vumber or Rur	al Route Number,	
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Accomplished in by the it.		ealcai	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medical Exami	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, de nination and/or	eath occurred at the tim r investigation, in my op	e, date and place, pinion, death occurr	and due to the red at the time,	cause(s) ar date and pl	nd manner as s lace, and due t	stated. to the cause(s)	
To the within			29b. Signature and title of certifier	> 0	0	29c. License	number		29d. Date s	signed (Month,	Day, Year)	
			30. Name and address of person who co			pe, Print)			,/	21025		
1	State	2	31. Date filed (Month, Day, Year)	32. Hegy tran's S	ignature	DITOTE	المكات ومعلا	-soury,	MD	<u> ∓180†</u>		

			For State Registrar	St	ate of M	laryland		artmen rtificate			and M		Reg. No.	005	26252		
	Physici	an	Decedent's Name (First, Middl	e, Last)								2. Date of De Month	Day	Year	3. Time of Death		
	/Medic	al	Hing One			1	Moy	4h Ch	Tour or	Location of	4 Dooth	Ju1y		005 ounty of Dea	12:10 p M		
	Examin	er	4a. Facility Name (If not institution Montgomery Ger			114			10wn, or		n Death			ntgome			
	Funeral		5. Social Security Number	6. Sex		ge (In yrs. la	ast birthday)	If Under	1 Year	If Under		8. Date of Bir	th		thplace (State or Foreign buntry)	7	
	Director		578 46 9404	1 X M	2□ F	80	Yrs.	Months	Days	Hours	Min.	(Month, Da Dec. 1	6 192	4	China		
	pu ,		Usual Residence of Decedent 10a. State 10b. County			100 Ciby	, Town or Lo	oation							10d. Inside City Limits	_	
	shov	'n				Too. Oily									1 ☐ Yes 2 🛣 No		
	the M	ecto	Maryland Mor	tgome	сy		<u>Silve</u>	r Spr 10f. Zip					10a. Citize	on of What Co	ountry?	_	
	with	ă	12920 Georgia Avenue					701. 2.19	209	006			USA				
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Exactions to notified at	Funeral Director	11. Marital Status	12. W	as Decedent		S. 13. \	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)		. Race - Ame		—	
9	after or Item		1 ☐ Never Married 🍇 Mar	ried 1	med Forces				_	n, Mexican Specify:	, Puerto	Hican, etc.)		Black, Whit	_		
21215-0036	iral', o	d by	3 Widowed 4 Divorced	Ÿ	Yes, Give ear or Dates:		1 ☐ Yes 2 No Specify:							pecify: As			
2-(72 h "natu	Completed	15. Deceder (Specify only highe				16a. Deced	dent's Usua kind of wor DO NOT us	rk done d	durina mosi	of worki	ng		of Business er Vic			
12	within ene.	dmo	Elementary/Secondary (0-12)	C	ollege (1-4or	5+)	me. i	Chef		,			Res	tauran	te		
Q	filed Hygi othar		17. Father's Name (First, Middle,	Last)				Спет		18. Mothe	r's Name	(First, Middle	, Maiden S	umame)			
<u>a</u> n	should be nd Mental marked c	To Be	Xiang Xi		Moy					Yı	ıe Ai		C	ao			
Maryland	s 1 and 2 should Health and Men Itam 27 Is marke other traumatic		19a. Informant's Name/Relations	hip <i>(Type, F</i>	rint)		19b. Mailír	ng Address	(Street a	and Numbe	or or Rura	l Route Numb	er, City or T	Town, State	Zip Code)		
	of Health of Health I Itam 27 I		Mae G. Moy / W	life					_						1and 20906		
ore	of He		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Remov	val from State	20b. Pl	ace of Dispo emetery, crer	natory or o	ne of ther plac	e)	D	ate	20c. Loca	ation - City or	Town, State		
Baltimore,	trant tant: tant:		`4 □ Donation 5 □ Other (S	pecity)											ing,Maryla	ıd	
Bal	permit. Pages. Department of I Important: If Its any injury or or once.	1 12	21. Signature of Funeral Service	Liotnsee	end	our						es Rin Ave S			1 Home g,MD 20904		
8760,	Finy sician and Medical Examiner the private transit street private transit street private transit street private transit street private transit street private transit street private transit street private transit street private transit street private street p	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listase of hour that initiated events resulting in death) Last	a	Due to (or as	s a consequ	rence of):	7							Onset and Death		
O. Box 6	death certif e attending d for use as	Physician/Medic	nysiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1	yes, outcom □Live birth □Pregnant a □Unknown	2 Fetal	death 3	Ectopic pr Other (sp					23	d. Date of de Month	livery Day Year	
rds, P	es tha igned be de	by	Part II. Other significant condition		ting to death	but not resu	ilting in the u	nderlying c	ause give	en in Part I.			obacco use Yes 2.⁄2	_	o the cause of death? robably 4 \(Unknown	1	
I Records,	The ate ha	Completed	hyperlip	den	nig							24a. Was auto perfo 1 \(\text{Yes}	psy ermed?	24b. Were a prior to death? 1 \(\sum \) Yes	utopsy findings available completion of cause of	,	
Vital	Phyaician: 'this certifica'ral director, p	Be	25. Was case referred to medical examiner?	Hospi	tal:				Othe	A.D.		(Check only			-		
o	og Phya ter this neral dii	on; To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28	npat Ba. Date of Inj (Month, D	ury	ER/Outpatier 28b. Time of Injury		8c. Injury Work	4 🗀 140	-	ne 5 🗌 Resi 28d. Describe			ocify)		
Division	Attan ar deat actor: by the	ertification;		gation not be	e. Place of Ir	njury - At ho		M reet, factory		Yes 2	-	28f. Location (City or To		Number or R	ural Route Number,		
	To the Hospital or within 24 hours afte To tha Funaral Dir completely filled in	O	29a. Certifier Certifyi	ng Physicie	n: To the bes	t of my know	wledge, deat	h occurred	at the tim	ne, date an	d place, a	and due to the	cause(s) a	nd manner a	s stated.	_	
	To the Hospital within 24 hours a To the Funeral Completely filled	edical		Exeminer:		of examinat									e to the cause(s)		
	To the within 2 To the complet	ž	29b. Signature and title of certifie)						e number			-		th, Day, Year)		
			108HL A	VAL	WD					317			July	1 26	2005		
	4		30. Name and address of person	who comple	ted cause of	death (Item	23a) (Type,	Print) RAAD	# 2	13 (soit	Lube	ni n	10 20	177		
	Sta Registi	-	30. Name and address of person Josph A BAII 31. Date filed (Month, Day, Year	8 2005	32. Fegis	trar's Signa	ture	mil	,				,				

			For 10f	State of Maryla	and / Depa			Mental Hy	/giene	
	amend i	te	State 10C, 10e, p. 1. Decedent's Name (First, Middle, Li	er FH, bg 8/2/0	₀₅ Cei	rtificate of L	Death	100000	Reg. No. () () 5	26253
	Physic							2. Date of D	Day Ye	3. Time of Death
	/Medi Examir		Doris Jea 4a. Facility Name (If not institution, gi		alth	4b. City, Town, or	Location of Dea	<u>July</u>	30, 2005 4c. County of D	11:04 AM
			McCready Memori	al Hospital		Crisfie	ld		Somer	set
	Funeral		Social Security Number 6.		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		irth 9.	Birthplace (State or Foreign Country)
	Director		217-26-4621 Usual Residence of Decedent	77	Yrs.			04/21/		rginia
	yland		10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits
	B Mar	ctor	MDSomers	et	Fairmour	Westo	ver			1 Yes 2 □ No
	with the Maryland a or 28a-f show	Director	10e. Street and Number			10f. Zip Code	21071		10g. Citizen of What	Country?
	death w	rai	TO BOX 142	9 Rumbley Rd.		21867	21871		USA	
36	s after or ite	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	Nas Decedent of His f Yes, specify Cubar □ Yes 2 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	o- 14. Race - A Black, W Specify:	merican Indian, /hite, etc.
21215-0036	"natural"	edk	15. Decedent's E		16a, Deced	lent's Usual Occupa	tion		16b. Kind of Busine	hite ss/Industry
215	within 72 ene. than "ns	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done di OO NOT use retired)	uring most of wo	rking	TOD. KING OF BUSINE	samoustry
21	e filed within al Hygiene. I other then vent, the Me	Com	10	none	Care	giver			Healthcar	e
pu	be filed within 7 stal Hygiene "n d other then "n event, Ine Media	Be	17. Father's Name (First, Middle, Las				18. Mother's Na	me (First, Middle	, Maiden Sumame)	
Maryland	permit. Pages 1 and 2 should be 1 Deperment of Heath and Mental I Important: If item 27 Is marked or any injury or other fraumatic eve once.	^L	Charles H. Johns				Vera Jo			
Ma	d 2 sl th and th and traur	1	19a. Informant's Name/Relationship Allen Armstrong/	**					per, City or Town, State Station, M	
	s 1 an I Heal Itam 2 other		20a. Method of Disposition	20b.	. Place of Dispos	sition (Name of		Date	20c. Location - City	
E O	Pages ent of nt: If i		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, crem	natory or other place	· .	02/2005		
Baltimore,	mit. I pertm cortai y inju	1	Signature of Funeral Service Lize			. I Memory . Name and Address .nman Fune			Hebron, Ma	aryland
8	Depe Impo	(ances La Chu	MOD2 MOD2	1 7				cess Anne,	MD 21853
			3a. Part1. Enter the disease, or conshock, or heart failure. List only	polications that caused the de-	ath. Do not ente	er the mode of dying	, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. CORONARY	4 ARTE	RY DISE	ASE			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
		- G	Sequentially list conditions, if any, leading to immediate	b. ABDOMIN Due to (or as a conse		RIIC AN	EURYS	<u>m</u>		
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		. 400.100 01/2					
o,	icate be executed physician and the burial-transit	Ä	resulting in death) Last	Due to (or as a conse	equence of):					
8760,	ate be nysicia he bu	dicai	(d						
9	artifica ing ph	- υ	IF FEMALE:							
.O. Box	v requires that the death certifi been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
٥,	The law requires that the tte has been signed by th page 2 should be detache	by Pl	Part II. Other significant conditions	ontributing to death but not re	sulting in the un	derlying cause giver	n in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ırdş	w require been sig should b	pe						1 🗆 '	Yes 2 2 10 3 □	Probably 4 Unknown
Records,		Completed						24a. Was	an 24b. Were	autopsy findings available o completion of cause of
		Con						perfo	ormed? death'	!
Vital	Physician: The lar this certificate has al director, page 2	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only o		
of	문 분들	- L	1 Yes 2 No 27. Manner of Death	1 Inpatient 2	ER/Outpatient 28b. Time of	3☐ DOA Other	4 Nursing H		dence 6 Other (Sp	pecify)
on	Attending Phyrdeath. sector: After thi	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	Work?	es 2 🗆 No	280. Describe i	how injury occurred	
Division	l or Attendi after death. Diractor: A	Certification:	3 Suicide 6 Could not b	e 28e. Place of Injury - At I	home, farm, stre			28f. Location (S	Street and Number or i	Rural Route Number,
ā	tal or s afte al Dir	Cert	4 Homicide	building, etc. (Spec	eify)			City or Tov	vn, State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysician: To the best of my kn niner: On the basis of examin and manner stated.	nowledge, death nation and/or inve	occurred at the time estigation, in my opin	, date and place nion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and di	as stated. ue to the cause(s)
	To T To I	Σ	29b. Signature and title of certifier			29c. License			29d. Date signed (Mor	
•			MD			00062	172		7/30/20	005
			30. Name and address of person who $SHARADRSAT$			Print) RKET ST	page	MAKE	MD 2185	,
	Sta	e					7000	JIJUNE	110 2103	
	Registr		AUG 0 2	2005 32. Regitrar's Sign	BA	book				

			State of Marylai		artment of Hertificate of L		- '	giene 2.005	26254
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		John Brooks Marvel				JULY Month	19 200	5 910 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) 124 Bloomingdale Avenue		4b. City, Town, or Federa		h *	4c. County of De	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs 221-26-2988 1 1 ★ 2 F	62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y, Year)	Birthplace (State or Foreign Country)
	Director	}	Usual Residence of Decedent	UZ			riay 2,	1945 Ma	ryland
	yland Now		10a. State 10b. County 10c. C	ity, Town or Lo					10d. Inside City Limits
	se-fst	ctor	MD Caroline		Federa1	sburg			1x Yes 2 □ No
	3a or 2	i Dir	10e. Street and Number 124 Bloomingdale Avenue		10f. Zip Code	1632		United S	States
200	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At them 27 is marked other than "natural", or items 23s or 28e-f show or other treumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced 12. Was Decedent Ever in to Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar I ☐ Yes 2 █ X No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. White
5	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done d	tion uring most of wo	rkina	16b. Kind of Busines	ss/Industry
7	ithin de.	npie	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired)			433 1 ***	
7	lled w lygier ther ti	S	17. Father's Name (First, Middle, Last)	Par	ts Manage		me (First Middle	Allen's H	atchery
2	ould be filed with Mental Hygiene arked other that atic event, the h	To Be	Brooks Miller Marvel				A. Sm		
Mal y	12 should h and Men 7 is marke treumatic		19a. Informant's Name/Relationship (Type, Print) Doris Elaine Parks/Sister		ng Address (Street a	nd Number or Ru	ural Route Numbe	r, City or Town, State	n, Zip Code) MD 21222
ב ע	s 1 and f Health item 27 other tr		20a Method of Disposition 20b.	Place of Dispos	sition (Name of	2)	Date	20c. Location - City	
Daltillo	Page ment o ent: if ury or			EMETE				SEAFORD,	
Dall	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other		21. Signature of Fundral Service Licensee		WATSON SEAFORD			HOME, IN 973	C.
			25a. Part1. Enterthe disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	ath. Do not ente	er the mode of dying	, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
J	Physician		Immediate Cause (Final disease or condition	YOCAR	DIAZ IN	1FARC	TION		Onset and Death
	/Medical Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	SIVE	CARDID	VASCUL	LAR D	1.56976	chronic
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse	quanca of):					
, S	e be ex sician e burial	dicai E	d d	querios or).					
0	tificati ng phy as the	ledic							
7. 20.	ilcien: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
	ss that the	by Ph	Part II. Other significant conditions contributing to death but not re	sulting in the ur	nderlying cause give	n in Part I.			to the cause of death?
5	equire	ted					1 🗆 Y	′es 2 □ No 3 □	Probably 4 Kunknown
וטפר	The law ate has b page 2 st	Completed					24a. Was autop perfor 1 Yes	sy prior t med? death	
ובם ע	clen: ertific ector,	Be	25. Was case referred to medical examiner? Hospital:		Other		ath (Check only o	ne)	
5	ding Phyel	n: To	27. Manner of Death 28a. Date of Injury	ER/Outpatien 28b. Time of		4 Nulsing r	,	lence 6 Other (S)	pecify)
5	ath. ath. rr: Afte	atio	1 ♥Natural 5 □ Pending (Month, Day Year) 2 □ Accident (Month, Day Year)	Injury		es 2□No			
	To the Hospitel or Attending Physicien: The I within 24 hours effer death. To the Funerel Director: Affer this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At the building, etc. (Special Special Spec	nome, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Number or m, State)	Rural Route Number,
	e Hospit 24 hour e Funere etely fills	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my kn 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	n occurred at the time vestigation, in my op	e, date and place inion, death occu	e, and due to the durred at the time, d	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To th within To th comp	Me	29b. Signardy and title of certifier Deputy My	mo	29c. License	number		29d. Date signed (Mo	nth, Day, Year)
	03		Jarisuan Etensen	1110	D14	664		JULY <	10 4005
	らつ		30. Name and address of person who completed cause of greathy (te	670,1	DENTOI	VMI	2168	29	
	Sta Registr	_	31. Date filed (Month, Pay, Year) 32. Projectar's Sign	nature	Coreti 1				

		•	1 = For State Registrar	State of Maryla		artment of			giene	5 26255
1.8			Decedent's Name (First, Middle, Last))				2. Date of De	ath	3. Time of Death
	Physici /Medic		Charlie	Frank M	CNary			July	31, 2005	
7	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	n, or Location of	Death	4c. County of D	Peath
*	*,		20746 Wolftrap S				Lexingto		St. Ma	
	Funeral		5. Social Security Number 6. Se	M 2006	s. iast birthday) Yrs.	If Under 1 Ye Months Da		Min. (Month, Da	v. Year)	Birthplace (State or Foreign Country)
	Director		411-72-5982 Usual Residence of Decedent	62				May 6,	1943 16	nnessee
	/land		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	Man a-f sh	ţċ	Maryland St. M	ary's		Lexingt	on Park			1 Tes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Coo			10g. Citizen of Wha	t Country?
	23a (23a)	al	20746 Wolftrap S	treet			20653			l States
	tema tema	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent If Yes, specify (of Hispanic Origii Cuban, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes Give	961 - 982	1 ☐ Yes 2	No Specify:		Specify:	Black
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or itema 23s or 28s-f show event, the Madical Examiner must be mailtied at	pa	15. Decedent's Edu	cation	16a Dece	dent's Usual Oc	ccupation		16b. Kind of Busine	ess/Industry
212	ZZ nic	Completed	(Specify only highest grad	College (1-4or 5+)	(Give	kind of work do DO NOT use re	one during most o ntired)	of working		
212	filed within Hygiene. Sther than "	E O	12	College (1-401 34)	Log	istics	Supervis	sor	Governme	ent Contractor
ם	al Hygi I other vent, I	Bec	17. Father's Name (First, Middle, Last)					s Name (First, Middle	, Maiden Sumame)	
<u>Na</u>		To I	William McNary					ldie Peete		
Maryland	CI 10 65		19a. Informant's Name/Relationship (T)	rpe, Print)		-		or Rural Route Numb		
	and ealth n 27		Barbara McNary/ Wi	fe		osition (Name o		Date	20c. Location - City	
0.0	Pages 1 nent of Hi int: if Itee iry or oth		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cre	matory or other	place)			
			4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			Cemete	-	3-4-2005		ls, Maryland Home, P.A.
Ba	permit. Departr Importu any Inje		Telly N. L.	. 1				Road, Le		•
中海道	7		Edward N. Brinstie 23a. Part 1. Enter the disease, or comp	Id, SF. MOOO.	2					Approximate
*	A		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	11 0	11 1				Interval Between Onset and Death
à	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cons	equence of):	<u> </u>	Jung	Cance	1	
4	Examiner				,					
	ri si	Jer	Saluentially list conditions if any, leading to immediate cause. Enter Undertying	Due to (or as a consi	equence or):					
	cuted	Examiner	that initiated events	c						
760,	ate be executed hysician and the burial-transit	Ä	resulting in death) Last	Due to (or as a conse	equence of):					
876	The law requires that the death certificate be executed te has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	dical		d						-
ox e	leath certific attending p	/Med	IF FEMALE:	23c. If yes, outcome of preg	nancv				23d. Date of	delivery
Bo	eath atten Ifor u	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time of	tal death 3	□Ectopic pregna □ Other (<i>specif</i>)	,		Month	Day Year
o.	at the de by the a	ysl	1 ☐ Yes 2 🗖 No 9 ☐ Unknown	9☐ Unknown		. , ,				
٠ <u>.</u>	res that igned b be deta	by Pł	Part II. Other significant conditions co	ntnbuting to death but not re	esulting in the u	inderlying cause	given in Part I.	23e. Did	tobacco use contribu	te to the cause of death?
g	quire on sig uld b							10	Yes 2□No 3月	Probably 4 Unknown
Records,	sw requ	olet						24a. Was	an 24b. Wer	e autopsy findings available to completion of cause of
Ä	The lay	Completed							ormed? deat	th?
ta		BeC	25. Was case referred to medical				26. Place o	of Death (Check only		
<u>></u>	S S	To	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie			sing Home 5 Resi	idence 6 Other (Specify)
0	E 6		27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Injury at Work?		how injury occurred	
Sio	Attending in death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				1 ☐ Yes 2 ☐ N		(Street and Number	Print Pauta Number
Division of Vital	or At after d Direct in by	Certification;	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	nome, farm, st cify)	reet, factory, off	lice		wn, State)	or Rural Route Number,
_	Hospital 24 hours a Funeral I tely filled		29a. Certifier 1 Certifying Phy	sician: To the best of my k	nowledge dea	th occurred at the	ne time, date and	place, and due to the	cause(s) and manne	er as stated.
	To the Hospital or Attendir, within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	dlcal		iner: On the basis of exami and manner stated.						
	To the Youthin 2 To the complet	Me	29b. Signature and title of certifier			29c. Lic	cense number	(1	29d. Date signed (A	Month, Day, Year)
)	S.		Tahin	Com	~	D_{r}	4112	8	8/2	05
4	7/1		30. Name and address of person who o							
			Patrick Cross, 2			ad, Hol	lywood,	Maryland 2	20636	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0	32. Regist as Sig	nature &	fresh	0			

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of H rtificate of L			ene 0 0 5	26256
	Physici /Medi		Decedent's Name (First, Middle, Last, JEROME WELSH M	ONTPLAISI	R			2. Date of Death Month	Day Yes	3. Time of Death
	Examir		4a. Facility Name (If not institution, give 702 ORCHARD MANO			4b. City, Town, or	Location of Dea	th	4c. County of D	eath WASHINGTON
	Funeral Director		5. Social Security Number 002–16–3408 6. Sec.	7. Ag	e (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. E 1924	Birthplace (State or Foreign Country) N.H.
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Be-f sh	Director	MARYLAND WASH	INGTON		ВО	ONSBORO			1 XYes 2 □ No
	with th	Dire	10e. Street and Number 702 ORCHARD MANO	R DRIVE		10f. Zip Code	21713	100	g. Citizen of What	
	ems 2	nera		12. Was Decedent in Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		Specify Yes or No-	14. Race - A	U.S.A. merican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumetic avant, the Medical Evarial at mastice rotified an once.	Completed by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🌠 Divorced	1 XYes 2 1 If Yes, Give Year or Dates:	√o WWTT ∣	1 ☐ Yes 2 ☐XNo	Specify:	to Hican, etc.)	Specify:	hite, etc. WHITE
15-0	in 72 h	oletec	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa kind of work done a DO NOT use retired.	luring most of wo	orking	6b. Kind of Busine	ss/Industry
	ed within rgiene.	Somp	Elementary/Secondary (0-12)	College (1-4or 5	+)		PRENEUR		RES	TAURANT
Maryland	ould be filed Mental Hygid Marked other Metic avant, II	Be	17. Father's Name (First, Middle, Last) SIMIUS E. MONTPL	ATCTD			18. Mother's Na ETJEN	me (First, Middle, Ma	aiden Sumame)	
aryl	should and Me s mark umetic	P_C	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street a		ural Route Number, (City or Town, State	a, Zip Code)
	and 2 lealth a m 27 ls		MARCIA D. GORSKI	, DAUGHTE	R 650	8 APPLETO		BOONSBOR		
Baltimore,	Pages 1 nent of H int: If ite iry or oti		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation; 5 ☐ Office (Specify)	emoval from State	l	natory or other place			Oc. Location - City	
altir	permit. Page Department Important: It any injury o		21. Signature of an eral Service License			RG CREMATO . Name and Addres			D NATION	RG, MARYLAND AL PIKE
<u>-</u>	80 = 8 8			<u></u>		BAST FUNE			RO, MARY	
	Physician		23a. Part . Enter the disease, or compile shock, or yeart hiture. List only or Immediate Cause (Final						t,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as	CORCN a consequence of):					
		er	Sequentially list conditions, if any, leading to immediate		a consequence of):	nevos	C) ENG:	>		
	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
8760,	ficate be executed physician and s the burial-transit	dical E		Due to (or as a	a consequence of):					
	artificat ing phy e as th		IF FEMALE:							
.O. Box	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 1 □ Pregnant at 1 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
S, G	as that gned b	by Pr	Part II. Other significant conditions con	tributing to death bu	it not resulting in the ur	iderlying cause give	n in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
Records,	w require been sig should b								2 5xNo 3 □ 1	Probably 4 Unknown
		Completed						24a. Was an autopsy performe	d? prior to	autopsy findings available completion of cause of
	/sician s certifi director	o Be	25. Was case referred to medical examiner? 1 ∑XYes 2 □ No	ospital:	nt 2 ER/Outpatient	O# -	~	ath Check only one)	- 2 TO: - /2	
Division of Vital	iding Phy th. : After thi funeral o	\vdash	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time of	28c. Injury Work	at	28d. Describe how		өспу)
Divis	To the Hospital or Attending Physician: Thin 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or l State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	er: On the basis of and manner stat		estigation, in my opi	nion, death occu	irred at the time, date	and place, and du	ie to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	() ! !	0	29c. License	number	29d.	. Date signed (Mor	nth, Day, Year)
			30. Name and address of perion who con	Seels le	oth (Item 22a) (Time 1	Print)	00112	66	JV1/ 2	9 05
HI	b+1		HNV	Leeks	580 lev7	Thein A	V J	AGEV-TO	WW. I	ud
	Sta Registra		31. Date filed (Month, Day, Year) AUG 0 2 20	32. Registra	ath (Item 23a) (Type, F SEI VV) r's Signature	hele	,		,	

			For State Registrar	State of Marylar	nd / Depa		ealth and N	Mental Hygi	•	. 90007
Sr	<i>yi</i> ₩ ₁		Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Medic		Marilynn Joyc	e	Mahome	ed		July 17	, 2005 Yea	8:10 A M
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death	1	4c. County of De	eath
			Forestville Health	& Rehab Cent	er		stville		Prince	George's
	Funeral Director		5. Social Security Number 6. Sex 119-40-9545	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth March Day,	^{9. B} Ca	inthplace (State or Foreign Country) Inada
7	2 >		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Lo	noation				10d. Inside City Limits
-	permit. Pages I amo 2 should be little writin 7 z hours after deain with fine maryland Department of Health and Mental Hygiene. Importent: If them 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examinal must be inclified at QDEs.	tor	Maryland Prince G		Forest					1 Yes 2 □ No
4	or 286	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
4	23e (alc	2809 Kirtland Av	enue		20747			Canada	
7	tams	Funeral		12. Was Decedent Ever in L Armed Forces?	I.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - An Black, Wi	nerican Indian, hite, etc.
50	or's and	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1		1 ☐ Yes 2 ♣ No	Specify:		Specify:	Black
Maryland 21215-0036	'nature	Completed by	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired	ition furing most of work	king 1	6b. Kind of Busines	ss/Industry
[7]	within tene. than	ршо	Elementary/Secondary (0-12) 12 years	College (1-4or 5+)	life.	Domestic			Private	
	Hygu other	BeC	17. Father's Name (First, Middle, Last)		.l		18. Mother's Nam	ne (First, Middle, M	aiden Sumame)	
a	Aenta Aenta rked tic e	To B	Vernon Mahomed				He1e1	n Waters		
lar)	and h		19a. Informant's Name/Relationship (Type			ng Address (Street a				
2,5	and ealth m 27 her tr		Renee' Mahomed-Was			Kirtland				
0	it of H or oth		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Re	emoval nom State		sition (Name of matory or other place	ı		0c. Location - City of	
Baltimore,	rtmen rtent: njury		'4 □Donation 5 □ Other (Specify)	Res	errect	ion Cemete	ery July	22, 2005	Clintor	e, Maryland
ם מ	Depa Impo any is		21. Signature of Funeral Service Lice is	townto		2. Name and Addres				
i i			23a. Pant. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final						st,	Approximate Interval Between Onset and Death
	h ysicia n /Medical		disease or condition resulting in death)	Due to (or as a consec		as with Me	etastasis	3		
E	Examiner				donos on.					
7	- =	ner	Sequentially list conditions, if any, leading to immediate cause. End of denying Cause (Disease or injury that initiated events	Due to (or as a consec	циелсе of):					
	ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	uonna of):					
/6U,	ician d	cal E		Doe to (or as a consec	luerice or).					
	phys s the	_	0							
	nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn		7			23d. Date of d	delivery
Division of Vital Records, P.O. Box 68	inat the death certificated by the attending phidetached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐Feta 4☐Pregnant at time of a 9☐Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
ר פֿ	d by t letach	Phy	9 ☐ Unknown Part II. Other significant conditions con		culting is the u	ndorhing oguso gwo	on in Port I	23e Did tob	acco use contribute	to the cause of death?
as,	signe signe d be o	b	Renal Failure, An					1 ☐ Yes	37	Probably 4 Unknown
Ö	w requires to been signed should be	etec	Kenar Parture, An	emia, beep v	enous .	THITOMOUSES	3	24a. Was an	1	autopsy findings available
He He	sicient. The law certificate has t irector, page 2 s	Completed					· · · · · · · · · · · · · · · · · · ·	autopsy perform	ed? prior to	o completion of cause of
Ia [tificat tor, pa	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only one		as 2□No
>	lysici lis cer direc	To B	examiner? 1 □ Yes 2 🌣 No	ospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Othe	r: 4 XNursing H	ome 5 Resider	nce 6 Other (Sp	pecify)
0 8	Attending Physician; r death. sctor: After this certifica by the funeral director,	on;	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		at	28d. Describe how		
OIS	leath. for: A the fu	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				′es 2 □ No			
	after d Direct	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, sti fy)	eet, factory, office		City or Town,		Rural Route Number,
	To the nospile of Authoring Prysticent. The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sicien: To the best of my known to the basis of examinating and manner stated.	owledge, deat ation and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occur	, and due to the car rred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
, ,	within 2 To the complet	Me	29b. Signature and title of certifier	. 🙃		29c. License	number	29	d. Date signed (Mo	
,) DWW	am		D 5	1520		07-21	- 05
)	(2)		30. Name and address of person who co			•				
			Bahram Pishdad, M	.D. 7801 01d	Branch	n Ave. #40	9 Clinto	on, MD 20	735	
	StaRegistr	. 9 , 2	JUL 2 7 2005	. Registrar's Sign	Apo	de la				

		For State Registrar	State of Ma		Depa	artment			lental Hy	ygiene Reg. 12.	005	26258
Physicia		1. Decedent's Name (First, Middle, Last	Rudolph	A. N	/IcCal	aster			2. Date of D		2005 ^{Year}	3. Time of Death 6:55 P
/Medica Examine		4a. Facility Name (If not institution, give Futurecare-Pinevi	street and number) ew Nursin	ig Home	2	4b. City, T	own, or Locati	con		4c. (County of Deat	orge's
Funeral Director		Usual Residence of Decedent	x 7. Ago	e (In yrs. last 82	Yrs.	If Under Months	Days Hou	der 24 Hrs. rs Min.	8. Date of Bi (Month, D			nplace (State or Forei untry) nnecticut
the Marylar 28e-f show	Director	Maryland Prince G	eorge's	10c. City, To	own or Lo		Jpper M	[arlbo	<u> </u>	10g Citiz	ten of What Co	10d. Inside City Limi
23e or		1305 Robert Le	wis Avenu	e			20774			Tog. Oniz	USA	unity:
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28e-f show other treumetic svent, the Medical Evantmer must be rediffed at	t by Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 TYPES 2 The If Yes, Give Year or Dates:	10		Was Decede If Yes, speci 1 Yes 2	ent of Hispanic fy Cuban, Mex		ecify Yes or N Rican, etc.)		4. Race - Amer Black, White Specify: Bla	e, etc.
filed within 72 he Hygiene. other then "natu ent, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5		6a. Deced (Give life. I	kind of work DO NOT use	Occupation done during retired)	nost of workii	ng		of Business/I	,
should be filed nd Mental Hygis i marked other umetic svent, L	To Be C	17. Father's Name (First, Middle, Last) Calvin O. McCal						Mart	(First, Middle ha McD	e, Maiden S	Sumame)	
alth and 27 is ma		19a. Informant's Name/Relationship (Ty Sarah McCalaster									Town, State, Z Lboro M	
t. Page rtment o rtent: If	1	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature 9 Funeral Service Licenter		ceme	tery, cren land	sition (Name natory or oth Vets	cem.	7/29/		Chel	tenham	
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· Va		30. Name and address of person who co Bahram Pishdad,					#310,	Washi	ngton 1	DC 20	032	
State Registra		31. Date filed (Month, Day, Year) JUL 2 7 2005	2. Registra	r's Signature	A.	<i>i</i>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 10a, b, c, e, f per inf 9846 8-19-05 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Manspac 40 AM dia 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Whington Montgomery Dome greater 5. Social Security Number 0 7. Age (In yrs. last birthday) If Under 1 6. Sex Funeral 9 Birthplace (State or Foreign FEB. 2, 1□ M 2□X Months Hours Days Min Yrs. 92 Director 126-18-0241 **GERMANY** Usual Residence of Decedent death with the Maryland 10b. County 10c, City, Town or Location 10a, State 10d. Inside City Limits Rockville permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once. MD. Montgonery 1 XYes 2 ☐ No Director South Orange Essex New Jersey 10e. Street and Number 10f. Zip Code 20852 10g. Citizen of What Country? 6121 Montrose Rd. 07079 110 Vose Avenue U. S. A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hugo Kahn Bertha Jonas 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Mansbach - Son 4619 Woodfield Road, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Beth Israel Cemetery 7/27/2005 Woodbridge, New Jersey 21. Signature of Funeral Service DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician artery atherosclerosis Caronavu disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760 as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has page 2 2 No certificate 1 ☐ Yes Division of Vital To the Hospitel or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 🗌 Yes 2 - No 4 Vursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 37464 ND 25 2005 July who completed cause of death (Item 23a) (Type, Print) KRIS S. nd address of person Rockville 6 Road montrose Mary State Registrar

			For State Registrar	State of Ma	aryland	-	artment o				iene ••• •2 0 0	5	26260
ı	Physici	- 6	1. Decedent's Name (First, Middle, Las ADA REBECCA MORGA			1-2-				2. Date of Deat Month JULY		_{Үөаг}	3. Time of Death 3:40 A M
	/Medic Examin		4a. Facility Name (If not institution, give ST VINCENT de PAU	street and number)	CENTI	ER	4b. City, Tov FROS	n, or Location	n of Death		4c. County of	f Death	
	Funeral Director		1/2-18-2049	X 7. Age □M 2X F	98 (In yrs. las	t birthday) Yrs.	If Under 1 Y Months Da	ear If Und ays Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day, 08/26/190		Cou	place (State or Foreign Intry) Sylvania
	show show	ž	Usual Residence of Decedent 10a. State 10b. County		10c. City,								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a-f	Directo	MD Allega 10e. Street and Number	Пу		La	Vale 10f. Zip Co	de		1	0g. Citizen of W	hat Cou	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23e or 28e-1 show any injury or other traumatic event, the Madical Exacilinational terminal and once.	Completed by Funeral Director	928 National Highw 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	ay 12. Was Decedent I Armed Forces? 1 □ Yes 2 ☒ N If Yes, Give Year or Dates:		1	Was Decedent f Yes, specify 1 ☐ Yes 2🎇			ecify Yes or No- Rican, etc.)		- Ameri , White	ican Indian, , etc. White
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8760,	Physician /Medical Examiner the private and the private the private the private the private that the private thas the private that the private that the private that the private	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Saus the light condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	no cause on each lin	a consequer	GRA nce of):				ch ID Pen		a	Interval Between Onset and Death
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ì	がんと Sta Registi		30. Name and address of person who among the Harjit Sidhu, 31. Date filed (Manth Cart) 200	M D 925 B		alch D	Print)						

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	Examin				ve street and numbe	er)		4b. City, Town, o	r Location of	Death		4c. Cour	ity of Death	
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				_ State	epartment of Health and Modertificate of Death		000	5 00000
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8	of Vital Records,	ding Physicien: The lav n. After this certificate has funeral director, page 2.	To	1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☑ Inpatient 2 ☐ ER/Outp				
		ding l	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Inju		28d. Describe how	v injury occurre	u .
	Division	Attender deat	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm				r o <i>r Rural Route Numb</i> er,
	Ö	after after I Dire	Certification:	4 ☐ Homicide building, etc. (Specify)		City or Town,	State)	
		To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, of the basis of examination and/one and manner stated.	leath occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the car red at the time, da	use(s) and man te and place, ar	ner as stated. nd due to the cause(s)
		To th To th Compl	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed	(Month, Day, Year)
		B		physical physical	12- 444283		7/25	105
_		B		30. Name and address of person who completed cause of death (Item 23a) (Tr. Robert Der (Cr) 9733 He	pe, Print) 1/huzy Dive	Be	le.	n.D
		Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sparle Drive			

Registrar

State

32. gistrar's Signature

6602 Church Hill Ed. Chestertown, MD. 21620

Frederick Delboy, M.D.

AUG 1 0 2005

31. Date filed (Month, Day, Year)

			1 - For Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylar		artment of He rtificate of D			ne . N2 0 0 5	26264
	Physicia		Mildred A					July 21,	Day Year 2005	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Lo		, , , , , ,	4c. County of Dea	ath
		Щ	Summerville at We		last hirthday)		inster	8 Date of Birth	Carr	
	Funeral Director			м 2√Д F 93			Hours Min.	8. Date of Birth (Month, Day, Y Apr 28,	1912 Cze	rthplace (State or Foreign country) echoslovakia
Marylan	a-f ehow	ctor	10a. State 10b. County Maryland Carro		ity, Town or Lo		estminst	er		10d. tnside City Limits 1 ☐ Yes 2X No
th with th	23s or 28	Funeral Director	10e. Street and Number 45 Washington Ro	ad		10f. Zip Code	21157	10g	. Citizen of What C	
be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent; or items 23s or 28s-f ehow importent: if item 27 is marked other than "natural", or items 23s or 28s-f ehow any injury or other treumatic event, the Medical Expirant must be routified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2½ No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
within 72 ha	iene. r than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupation kind of work done dur DO NOT use retired) Homemake:		ing 16	b. Kind of Business	•
y land y	Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) "unknown"			1:	8. Mother's Name Ann J	icha	iden Sumame)	
d 2 sho	th and 7 is m treum		19a. Informant's Name/Relationship (Ty) George F. Novak,			ng Address (Street and Seven Oak			-	Zip Code)
	item item		20a. Method of Disposition	20b.		sition (Name of matory or other place)	•		c. Location - City o	r Town, State
Dermit, Pages	tment tent: if jury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	C		Cremations	l l	3/2005	Hampstea	ad, MD
	Departiment any n		21. Signature of Funeral Service License	M0072	3. 22	2. Name and Address 934 South	constitution was	Eline Fun		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea	th. Do not ent	er the mode of dying,	such as cardiac o	or respiratory arrest	~~~	Approximate Interval Between
	hysician Medical		Immediate Cause (Final disease or condition resulting in death)	mela	tatic	- Colon	Conce	er		Onset and Death
	xaminer			Due to (or as a conse	quence of):	I ag	4			724
þ	sit	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):	-				,
te be executed	been signed by the attending physicien and should be detached for use as the buriat-transit	cai Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
ath certificet	tending phy	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn		Ectopic pregnancy			23d. Date of de	
he de	y the at	ysici	1 Yes 2 No	4☐Pregnant at time of 9☐Unknown	death 5 ☐	Other (specify)			MOREIT	Day Year
The law requires that the death certifice	n signed b	by	Part II. Other significant conditions cor	tributing to death but not re	sulting in the u	nderlying cause given	in Part I.		_	to the cause of death?
	ate has page 2	Completed		W 6				24a. Was an autopsy performe	prior to	
sicien:	certific rector,	o Be	25. Was case referred to medical examiner?	ospital:	7500	Other		(Check only one)	-/	gssested
To the Hospitei or Attending Physicien:	Iter this	\vdash	1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		me 5 🗌 Residenc 28d. Describe how		geify) Jung
ei or Atter	within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At h building, etc. (Special		eet, factory, office	2	28f. Location (Stree City or Town, S		lural Route Number,
Hospit	within 24 hours effer or to the Funeral Director Completely filled in by	Medical (29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sicien: To the best of my kn ner: On the basis of examinand manner stated.	owledge, death ation and/or in	n occurred at the time, vestigation, in my opin	date and place, a ion, death occurre	and due to the caused at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
To	withi To the	Σ	29b. Signature and title of certifier	relation	nD	29c. License n	2244.	29d	Date signed (Mon	th, Day, Year)
•	20		30. Name and address of person who co	· ·		,		1157		6
	Sta	te	31 Date filed (Month Day Year)	32. Registrar's Sign	aturo	4	בב, ואט ב	LTJ/		

	1	npend item#23 - State Registrar		Oldic of Mi			ate of Death			N2005		261
	17	Decedent's Name (First, in the content of the	Middle, Las	st)			210 01 20 011	2. Date	of Death		3. Time	e of Death
ysiciai Iedica	_	Michael An	thony	Nixon				Aug		O1. 2005	1	00
nine		4a. Facility Name (If not inst	_			4b. Ci	ty, Town, or Location	of Death		4c. County of De	eath	
(C), A		Southern Mar 5. Social Security Number	cylano		e (In yrs. las		linton	or 24 Hrs. 8. Date	of Righ	Prince	George	
al or		153-42-6793 Usual Residence of Decede	1	½ M 2□F	54	Yrs. Month			h. Dav. Ye	ear)	Country)	
		10a. State 10b. Co			10c. City,	Town or Location					10d. Inside	-
	Director		N/A		Wa	shington	7. 0. 1.		10			/es 2□N
		10e. Street and Number 254 Oneida	Stree	t. N.E.		101.	Zip Code 20011		10g.	. Citizen of What (USA	Country?	
	Funeral	11. Marital Status		12. Was Decedent		. 13. Was De	cedent of Hispanic O pecify Cuban, Mexica	rigin? (Specify Yes	or No-	14. Race - Ar	mencan Indian	١,
	ል	1 Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Dive		Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:			pecify Cuban, Mexica 2 □ x No Specify		5.)	Specify:B1		
	eted	15. Dec (Specify only I	cedent's Ed			16a. Decedent's U (Give kind of	work done during mo	ost of working	161	b. Kind of Busines	ss/Industry	
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		17. Father's Name (First, Mi	iddle, Last)			LUDITC Hea	18. Molh	Specialist her's Name (First, M		strict of (iden Sumame)	COlumbia	Gove
1	To Be	Crawford T.	. Nix	on			Virg	jinia Urdi	ales			
ľ		19a. Informant's Name/Rela	ationship (Type, Print)		19b. Mailing Addre	ess (Street and Numb	ber or Rural Route N	lumber, C	ity or Town, State	e, Zip Code)	
2		1 XBurial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			0-1-		C	114945C	· /		925	-
OUC		21. Signature of Funeral Se	ervice Licer		Gate	Franc	and Address of Facil	lins Fune	ral 1	lver Spr Home Inc		
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			1 - State Registrar C6	partment of Health and Men ertificate of Death	, ,	e 2005	26266
	Physici /Medic		1. Decedent's Name (First, Middle, Last) GLENDORA V. OFFU	T T T T T T T T T T T T T T T T T T T	Date of Death Month Duly 24	y 2005	3. Time of Death 7:42A M
	Examir	er	4a. Facility Name (If not institution, give street and number) 12117 Valleywood Drive	4b. City, Town, or Location of Death Silver Spring		c. County of Death Montgo	mery
L	Funeral Director		5. Social Security Number 218-24-0656 Output 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 1	y) If Under 1 Year If Under 24 Hrs. 8. [Months Days Hours Min. JU	Date of Birth (Month, Day, Yea 1ne 15, I	9. Birti 924 Ma	nplace (State or Foreign untry) aryland
	e Maryland te-f show	ctor	10a. State 10b. County 10c. City, Town or I	Location er Spring			10d. Inside City Limits 1 Yes 2 □ No
	h with th	ai Dire	10e. Street and Number 12117 Valleywood Dr	10f. Zip Code 20902	10g. C	U.S.A.	•
036	rurs after deat al', or Items 2 Examiner mu	by Funeral Director		. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No- n, etc.)	14. Race - Amer Black, White Specify: B	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Items 23e or 28e-f show any injury or other traumatic event. The Medical Exam har must be notified at ADGS.	Be Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of working DO NOT use retired) Lesperson	S	Kind of Business/l Sears & Roebuck	ndustry
yland	should be file and Mental Hy s marked othe tumatic event,	To Be C	17. Father's Name (First, Middle, Last) James Jackson		ie Jack	son	
, Mar	and 2 shi lealth and m 27 is m		Hazel Jackson- Sister 123	iling Address (Street and Number or Rural Rot 117 Valleywood Dr	Silver	Spring	g, MD20902
timore	. Pages 1 Iment of H tant: If Ite jury or ott		4 Donafion 5 Other (Specify) Geo. We	position (Name of ematory or other place) ash. Cem. 7/26/2	2005	Location - City or 1 Adelphi	, MD
Ba	permit. Page Department of Important: If any injury or		Derige K. Award	246 N. Washington	St Roc		Home,P.A. , MD 20850
	Physician /Medical Examiner		23a. Part1. Enter the disease, of complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE Due to (or as a consequence of):	nter the mode of dying, such as cardiac or res HEART FAILURE	piratory arrest,		Approximate Interval Between Onset and Death MONTHS
8760,	be executed initial right and purial-transit	dicai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
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al Reco	i. The law requires that the crate has been signed by the page 2 should be detached.	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑N	prior to co	opsy findings available ompletion of cause of
Division of Vital Records,	Attending Physician: The death. ector: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 2 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at 28d. I			(fy)
Divis	tal or Attents after deats Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		Location (Street a City or Town, Star	nd Number or Rui le)	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, dea 2 ★ Medical Examiner: On the basis of examination and/or i and manner stated.	ith occurred at the time, date and place, and d nvestigation, in my opinion, death occurred at	due to the cause(s t the time, date ar	s) and manner as and place, and due	stated. to the cause(s)
	To To Com	M	29b. Signature and title of certifier	29c. License number D50678		ate signed (Month, July 26	· _ ·
_	6		30. Name and address of person who completed cause of death (Item 23a) (Type Rajeez Batra, MD 11120 New H	ampshire Ave Silve	er Spr	ing, MD	20904
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2.8 2005 32. Pegistrar's Signature	berle			

Charles Francis o'Connell, Jr. Second Control July 28, 2005 6:50 PP		State of Maryland / Dep	artment of Health and Mental	3							
Charlotte Hall Veterans Home Oliver 1998 Same State State ate Same State /Medical	Charles Francis O'Connell, Jr.	Month July	Day Year 28, 2005 6:50 PM								
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Charles O'Connell	after death with to or Items 23e or 2 ticker trivel be to 7 Funeral Directions of Funeral Directions of the or 1 february of Funeral Directions of the or 1 february of Funeral Directions of the or 1 february of Funeral Directions of the or 1 february of the or	21675 Weatherby Lane 11. Marital Status 1 □ Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1	20653 Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	U • S • A • 14. Race - American Indian, Black, White, etc.							
Charles O'Connell	within 72 hours ene. then "neturel; ite Medical Era	15. Decedent's Education (Specify only highest grade completed) 16a. Dece (Giv.	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	White 16b. Kind of Business/Industry							
23. Part. Error the disease, or complication that accused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate classes (printing in death). The disease of each line. The disease of each l	matic event.	17. Father's Name (First, Middle, Last) Charles O'Connell	18. Mother's Name (First, Mi Mary Lamb	iddle, Maiden Sumame)							
23. Part. Error the disease, or complication that accused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate classes (printing in death). The disease of each line. The disease of each l	nit. Pages 1 and 2 s artment of Health an ortant: If item 27 Is. injury or other treu.	Charles O'Connell 19a. Informant's Name/Relationship (Type, Print) Lois K. O'Connell / Wife 21675 Weatherby Lane Lexington Park, Maryland 20a. Method of Disposition 1									
State Stat	Pnysician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one eause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	P.O. Box 279 Leonardtow Iter the mode of dying, such as cardiac or respirator	rn, Maryland 20650-0279 ory arrest, Approximate Internal Potymon							
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Dullding, etc. (Specify) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filled (Month, Day, Year) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Year) 32 Fegistrar's Signature	equires that the sen signed by It ould be detach	Part II. Other significant conditions contributing to death but not resulting in the to		Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □Unknow							
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Dullding, etc. (Specify) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and dudress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filled (Month, Day, Year) 33. Page filled (Month, Day, Year) 34. Promicios Building, etc. (Specify) City or Yown, State) 29a. Certifier (Check only one) 1	ending Physici eath. or: Atter this cer the funeral direc cation: To B	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Mann of Death 12. Natural 5 Pending (Month, Day Year) 2 Accident investigation Hospital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work? 28d. Description	Residence 6 Other (Specify)							
AMMONT MD DO060120 7/29/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ref. Md W. Hagothmn 100 Hospital Rd Prince Fredrick, MD 20 State 31. Date filed (Month, Day, Year) 37 Registrar's Signature	Hospitel or Att 4 hours after d Funerel Direct ely filled in by ical Certifie	4 Homicide determined 289. Place of Injury: At nome, tarm, st building, etc. (Specify) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in	City of	r Town, State)							
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3 July 28th, 2000 3

O'Connell J

O Charles F

			1-	For State Registrar		State of	Marylar	nd / Depa	artment rtificate			Mental F	lygien	~ ~ ~ ~	2020
- 22	Physici	an	1. D	Decedent's Name (First, Middle	, Last)		0.	/-				2. Date of Month		ay Yea	3. Time of Death
	/Media	al	4a.	LOUISA Facility Name (If not institution	give st	reet and num	rec	ple	S 4h City T	own orloc	ation of Deat		20	c. County of De	7 #7/C M
	Examir	ier		CNRC	, 9.40 0.	root and man			C	21	NTO	N		P	G.
	Funeral Director		5. S	Social Security Number	6. Sex	M 2 📭	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Months		Under 24 Hrs ours Min.		Birth Day, Yea	9. 8	irthplace (State or Foreign ountry)
	ט		-	ual Residence of Decedent			<u> </u>	/					5		exas
	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a on 28a-f show event, I're Medical Examinar must be notified at	ro	10a	. State 10b. County	פיק בין	Papar	10c. C	Ac C	cation	JA					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28a	Funeral Director	10e	e. Street and Number	<u> </u>	Ocel	901	/ ^	10f. Zip (Code			10g. C	itizen of What (Country?
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21215	C 1 32	Completed	E	(Specify only highes Elementary/Secondary (0-12)	t grade	completed) College (1-	-4or 5+)	(Give	kind of work DO NOT use	done durin retired)	g most of wo	rking	100.	\(\rightarrow\)	/
	filed with Hygiene. other than	e Cor	17.	Father's Name (First, Middle,	Last)			Do	me		Mother's Na	me (First, Mid	dle, Maide	n Sumame)	Te
/land	should be filled within and Mental Hygiene. I marked other than umatic event, Ite M	To B	~	James D	, 1	Naal	oner	-			Han	nah			Un-avail.
Mary	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		198	a. Informant's Name/Relations	nip (Typ	7	aucht.	19b. Mailir	ng Address	Street and I	Number or R	ural Route Nu	mber, City	or Town, State	Zip Code)
	of Healt of Healt if item 2 or other		20a	. Method of Disposition	7//0	/	—	Place of Dispo	sition (Name	e of ner place)	NOTI	Date	20c.	Location - City of	or Town, State
Baltimore	permit. Pages Department of I Importent: If it any injury or o			1 ▼Burial 2 □ Cremation 2 4 □ Donation 5 □ Other (S)	secify)		State So	with t	ark	em.	07-	28-0	Ke	servell	N.M.
Ba	permit. Pag Department Important: I any injury o		21.	Signature of Funeral Service	icense	1		4	2. Name and	Address of	Facility 1	11111	Tomo		nd 26748
	Ein		23	a. Part1. Enter the disease, or shock, or heart failure. List	complic	ations that ca	used the dea sch line.	th. Do not ent	er the mode	of dying, su	ich as cardia	c or respirator		PICHINS	Approximate Interval Between
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	led nsit	Examiner	cau	quentially list conditions, any, locating to larm ediate use. Enter Underlying use (Disease or injury		Duato (a	or as a conse	quence of)							
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ox 6	eath certific attending p	Physician/Med		FEMALE: b. Was decedent pregnant	23		ome of pregn rth 2 ☐ Feta		Tetesis see					23d. Date of d	elivery
O. B	at the deat by the atte tached for	ysicia		in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			ant at time of		Ectopic pred Other (spec			-01.00	- [Month	Day Year
α.	res that the igned by be detacted	by Ph	Parl	t II. Dther significant condition	ns cont	ributing to de	ath but not re	sulting in the ur	nderlying car	use given in	Part I.	23e. D	id tobacco	use contribute	to the cause of death?
Vital Records,	w require been sig should b		-									1)	Yes 2	2 No 3 I	Probably 4 Unknown
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ita		Be C		Was case referred to medical examiner?						26.	Place of De	1∐ Ye ath (Check on	s 2 N ly one)	o 1 □ Y€	9s 2□ No
of	Phys this ral dii	은		1 ☐ Yes 2 Ø No Manner of Death	Ho	spital: 1 🔲 In		ER/Outpatien			Nursing F	Home 5 ☐ R		6 ☐Other (Sp	ecify)
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Division		Certification:		3 Suicide 6 Could r 4 Homicide determi		28e. Place o buildin	of Injury - At h g, etc. (Speci	nome, farm, str	eet, factory,	office			n (Street a Town, Sta		Rural Route Number,
	To the Hospital or Al within 24 hours after To the Funeral Direc completely filled in by		298	a. Certifier 1/2 Certifyin (Check only 2 Medical I	g Physi	cien: To the	best of my kn	owledge, death	occurred at	t the time, d	ate and place	e, and due to t	he cause(s) and manner a	as stated.
	To the He within 24 To the Fe complete	Medical	29h	one) 2 Medicel		and mann	er stated.								ue to the cause(s)
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8			1. Decedent's Name (First, Midd	lle, Last)			-					2. Date of Dea	ath Day	Yea	3. Time of Death
	Physici /Media		Dominic	Page								JULY	22	, 2005	9:07P. [™]
	Examir	er	4a. Facility Name (If not institution	, 3		,				Location of	of Death		1	County of De	
1966			PRINCE GEORGES 5. Social Security Number			NTER ge (In yrs. la	et hirthday)	If Under	EVER	If Under	24 Hrs	8. Date of Birt			EORGES
	Funeral Director		578-21-9057	6. Sex 1 X M 2 □	F /. A	ge (III yrs. Ia 1		Months		Hours	Min.	(Month, Da Mar. 20	y, Year)	9.1	irthplace (State or Foreign Country) Jash., DC
- 12			Usual Residence of Decedent				<u> </u>					rial. 20	, 1).) <u> </u>	asii., DC
	ylanc how		10a. State 10b. County	1		10c. City,	Town or Lo	ocation							10d. Inside City Limits
	r 28a-f ehow	cto	DC						Wa	ashin	gton	1		-	1 X Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number					10f. Zip	Code				10g. Citize	en of What (
	death with ns 23a or nust be	œ	5601 Ead	· · · · · · · · · · · · · · · · · · ·							019				d States
	ltems	nue	11. Marital Status 1 XNever Married 2 Ma	12. Was	Deceden ed Forces Yes 2 🔀	t Ever in U.S ? 7 No	5. 13.	Was Deced If Yes, spec	dent of His cify Cubar	spanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	- 14	I. Hace - An Black, Wi	nerican Indian, nite, etc.
36	irs aft	by F	3 ☐ Widowed 4 ☐ Divorce	. If Ye	s, Give			1 🗆 Yes	2 ፟X No	Specify:			5	Specify:	Black
5-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-1 ehow officer must be neithed at	ted	15. Decede	nt's Education			16a. Dece	dent's Usua	al Occupa	ition			16b. Kind	d of Busines	s/Industry
215	c * 1	ple	(Specify only higher Elementary/Secondary (0-12)		ited) ge (1-4or	5+)	life.	kind of wo DO NOT us	rk done d se retired)	uring mos)	t of work	ing			
2121	ygien gerth	Completed	8th					S	tudei					Nor	ie
nd	d oth	Be	17. Father's Name (First, Middle							18. Mothe	er's Nam	e (First, Middle,			
yla	ould Men varke	ပ္		n Brown									sha I		
Maryland	s 1 and 2 should be filled within "if Health and Mental Hygiene. item 27 is marked other than "item other traumatic event, the Mes		19a. Informant's Name/Relation									al Route Numbe	-		
	and lealt m 2 her		Nikisha Pag 20a. Method of Disposition	<u>e - Mot</u>	her	20b. Pla	560 ace of Dispo	Ol Eac	ds St	t., N	I.E.	Wash.,	20c Loc	20019	or Town State
ק	ages nt of . If it		1 X Burial 2 ☐ Cremation		from State	Cei	metery, crei	matory or o	itner place	3)		/2005		andove	
altimore,	it. Printme	}	4 Donation 5 Other (21. Signature of Funeral Service			nali		2. Name ar				tewart			•
Ba	permit. Pages 1 Department of H Important: If ite any Injury or oti once.		MALIT	- < Va	er t	1 111	,				.,	l., N.E.			
	I make the		23a. Part 1. Enter the disease, c shock, or heart failure. Lis	or complications	that cause	ed the death.	Do not en	er the mod	le of dying	g, such as	cardiac	or respiratory ai	rrest,	-	Approximate
	Physician		Immediate Sause (Final												Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. S	e to (or a	s a conseque	ence of):	m !) r- c	1492					
é	Examiner		Carriertielly list conditions	b											
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) D	e to (or a	s a conseque	ence of):								
	tate be executed oblysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
8760,	certificate be execul Iding physician and Ise as the burial-trar	E	robanning in double, East		ie to (or a	s a conseque	erice or):								
87	physicate sthe	Physician/Medical		d											
9 x	leath certifica attending ph	/Me	IF FEMALE:	23c. If ye	s, outcom	e of pregnan	ісу						23	ld. Date of d	elivery
Box	Jeath atter	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No			2 ☐ Fetal of dea		Ectopic pr Other (sp						Month	Day Year
P.0.	that the died by the detached	hysi	9 Unknown	9 🗆 ।	Jnknown										
	res that signed b	by P	Part II. Other significant condit	ions contributing	to death	but not resul	lting in the u	nderlying c	ause give	n in Part I		23e. Did t	obacco us	e contribute	to the cause of death?
Vital Records,	·- 0) T	edt										10	Yes 2 🖳	No 3□	Probably 4 □Unknown
၁၁	aw as b	Completed										24a. Was	an	24b. Were	autopsy findings available completion of cause of
Ä	The late had page	E O										yes Yes	rmed?	death	7
'ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?							26. Place	of Deat	h (Check only o	ne)		
of V	Physician: this certific ral director,	ို	1X Yes 2 No	Hospital:	1 🗌 Inpat		R/Outpatie			4 🗆 140	rsing Ho	me 5 Resid			pecify)
no		-u	27. Manner of Death 1 □ Natural 5 □ Pend	ing	Date of Inj (Month, D	ay Year)	28b. Time o Injury		8c. Injury Work	at	/	28d. Describe I			
Division	Attending r death.	Certification:	3 Suicide 6 □ Could	d mad by	22-0		iourn 20			/es 2 🕒	TNO	SUBJE 1			
Σį	or Al	rti	Homicide deten	mined 286.	building, e	njury - At hon atc. (Specify)		reet, ractory	у, опісе			City or Tov	vn, State)		Rural Route Number,
_	spital ours neret filled		29a, Certifier 1 Certify	ing Physician: 1	o the bes	STR.	_	h occurred	at the tim	e. date an					Mygow D. C
	To the Hospital or Attent within 24 hours after deatl To the Funeret Director: completely filled in by the	edical		I Examiner: On	the basis manner s	of examination	on and/or in	vestigation	, in my op	pinion, dea	th occur	red at the time,	date and p	place, and d	ue to the cause(s)
	To th Withir To th	Me	29b. Signature and title of certifi	er h				290	c. License				29d. Date	signed (Mo	nth, Day, Year)
			MAMIRAO	mo U	Sull	2 au	V		OC.	LIF.			JULY	23, 2	2005
0.	(5)		30. Name and address of person	n who completed	cause of	death (Item	23а) (Туре,	Print)	1 D	C:		_ n_1.		3.4	-1 1 01001
1			MARGARITA	D. KU	RET	1		11	T Le	ıшı St	reet	_ Balti	unore	, mary	71and 21201
	Sta Regist		31. Date filed (Month, Day, Year		. Regis	trar's Signatu	10-	Les.							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

7. Age (In yrs. last birthday)

61

Yrs

10c. City, Town or Location

Certificate of Death

Months Days

4b. City. Town, or Location of Death

Hours

Leonardtown If Under 1 Year If Under 24 Hrs.

	W + W	ឣ	Maryland St. Ma	ary's		Lexingt	on Pa	ırk		
	h the	<u>F</u>	10e. Street and Number				Zip Code			
	23a c	ai D	20692 Willows Ro	oad		20	653			
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the M Department of Heatth and Mental Hygiene. Important: If item 27 ie marked other then "natural", or iteme 23s or 28s-f any injury or other traumatic event, the Medical Examiner must be notified once.	Completed by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		If Yes, s	cedent of H specify Cuba s 2 X No	lispanic Origin? (an, Mexican, Pue Specify:	Specify rto Rica	/ Yes or No- an, etc.)
Š	2 hou	ted	15. Decedent's Ed (Specify only highest gra	lucation	1	6a. Decedent's U	Isual Occup	ation during most of we	orkin a	
121	within 7 ene. then "r	omple	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Homema	Tuse retired	d)	,, king	
0	Hygi other	e e	17. Father's Name (First, Middle, Last)			Homeme	INCI	18. Mother's Na	ıme (F	irst, Middle,
lan	Ald be Aental rked tic ev	0 8	Manuel Pena					Marie :	Stai	nford
Mary	nd 2 should be filed within alth and Mental Hygiene. 27 ie marked other then r traumatic event, the Me		19a. Informant's Name/Relationship (Inving Pierson/ Inving Pierson/ Invince Piers			19b. Mailing Addr 20692 Wil				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition 1 □ Burial 2 ■ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cem	e of Disposition (etery, crematory	Name of or other place	ce)	Date	9
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Bervice Licen	1500	2000	22. Name	and Addre	ss of Facility B1	rins	sfield
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused one cause on each line	the death.	Do not enter the r	Holl node of dyir	ywood Ro	ac or re	• Leon
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Cardiac Due to (or as a G I Ble	consequer ed	nce of):				
38760,	ate be executed hysicien and he burial-transit	Completed by Physician/Medical Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. <u>Hyperka</u> Due to (or as a	1em1a consequer		ease			
of Vital Records, P.O. Box 68760,	Physician: The law requires that the death certiticate be executed this certiticate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit	ysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	☐ Fetal de	ath 3□Ectopi	c pregnancy (specify) _	,		
ds, P	uires that signed b lid be deta	d by Pt	Part II. Other significant conditions of	ontnbuting to death bu	t not resultir	ng in the underlyin	ng cause giv	ren in Part I.		23e. Did to
Recor	hysician: The law req his certificate has beer I director, page 2 shou	ompiete								24a. Was autop perfor
ital	an: rtifica	Bec	25. Was case referred to medical					26. Place of D	eath (C	
1	nysici nis ce direc	ToE	examiner? 1 □ Yes 2 🏋 No	Hospital: 1 ☐ Inpatier	it 2 X EP	VOutpatient 3□	DOA Ott	ner: 4 🗆 Nursing	Home	5 ☐ Resid
0	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation			Bb. Time of Injury M	28c. Injui Woi 1 [ryat rk? Yes 2 □ No	280	d. Describe h
Division	ro the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medicai Certification	3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of Inju building, etc	ry - At home (Specify)	e, farm, street, fac	ctory, office		28f	Location (5 City or Tox
	ne Hospi 24 hour ne Funer detely filk	dicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	nysicien: To the best on the basis of and manner state	examination	edge, death occur and/or investiga	red at the ti	me, date and place opinion, death occ	ce, and	due to the dat the time, d
	ro th	ž	29b. Signature and title of certifier				29c. Licens	se number		

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

James McQuiston, M.D.

State of Maryland / Department of Health and Mental Hygiene 2. Date of Death Month Day Year July 2005 26, 00:06 4c. County of Death St. Mary's Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June 14, 1944 California 10d. Inside City Limits 1 ☐ Yes 2 ☐ No log. Citizen of What Country? United States Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Own Home Maiden Sumame) er, City or Town, State, Zip Code) Park, Md 20653 20c. Location - City or Town, State harlotte Hall, Md Funeral Home, P.A. ardtown, Md 20650-0279 Approximate
Interval Between
Onset and Death
10Min Unknown Unknown 23d. Date of delivery Month Year bacco use contribute to the cause of death? es 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes X No **¾**□ No 2 💢 No ne) lence 6 Other (Specify) now injury occurred Street and Number or Rural Route Number, vn, State) cause(s) and manner as stated. date and place, and due to the cause(s) 29d. Daje signed (Month, Day, Year)

State Registrar

= For State Registrar

5. Social Security Number

570-66-3141

10a. State

Maryland

Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

Martha Jean Ceclia Pierson

St. Mary's

1 ☐ M 2 X F

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

10b. County

D0062796

St. Mary's Hospital ER Leonardtown, Md

			riease i				nt of Health a				
			1 - For State Registrar	Otato or Ivia	•	-	te of Death	11,011		.No2005	26276
			Decedent's Name (First, Middle, Last)						Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		LINDA NORRIS	PEREZ					JUL 2	2 2005	7:40 PM
	Examin	er	4a. Facility Name (If not institution, give s		Tell Till	4b. City	, Town, or Location of			4c. County of Deal	
-	Funeral		NATIONAL NAVAL ME 5. Social Security Number 6. Sex	7. Age	(In yrs. last birt		BETHESDA er 1 Year If Under 2	24 Hrs. 8. [Date of Birth	MONTGO 9. Birt	OMERY thplace (State or Foreign ountry)
	Director		385-56-0921	[™] ¥F¥ 5	3	Yrs. Months	Days Hours	Min.	Date of Birth Month, Day, Y NOV 16	,1951 Mi	ch_
	ehow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location					10d. Inside City Limits
	e-feh	ctor	Va Loudoun			Aldie					1 ☐ Yes 24☐ No
	be filed within 72 hours after death with the Maryland tal Hyglene. The Hyglene of the heart of theme 23a or 28e-f show do ther then "natural", or theme 23a or 28e-f show event, the Medical Examinar must be incitived at	Director	10e. Street and Number	Lakian 6	n	10f. Z	ip Code			. Citizen of What Co	ountry?
	eath v	Funeral	24767 Stone S	12. Was Decedent E		13. Was Dec	20105	zin? (Specify		JSA 14. Race - Ame	erican Indian.
0	after d		1 Never Married 2XXIIarried	Armed Forces? 1 ☐ Yes 2 🏋N		If Yes, sp	edent of Hispanic Origeoffy Cuban, Mexican. 2 No Specify:	, Puerto Rica	n, etc.)	Black, Whit	_
0500-6171	filed within 72 hours after Hygiene. Ither then "natural", or Ite Int, the Medical Examins	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	5/5					Specify: Bl	
<u> </u>	n 72 h "natu	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a.	Decedent's Us (Give kind of w life, DO NOT	ual Occupation ork done during most use retired)	of working	16	b. Kind of Business	Industry
7 7	d with	mo	Elementary/Secondary (0-12) 12th	College (1-4or 5-	F1)	ome ma			I	Domestic	
2	be filed ital Hygi id other event, I	Bec	17. Father's Name (First, Middle, Last)	le o			1	,		iden Sumame)	
Maryiand		은	Robert B Hic		106	Admillion Address	ss (Street and Numbe		E Scot		Zin Cada)
<u> </u>	9 F = 9		19a. Informant's Name/Relationship (Type Ronald Perez (tone sta			acceptance and acceptance	
คั	is 1 and of Health item 27 other tr		20a. Method of Disposition		20b. Place of cemeter	Disposition (N. crematory or	ame of other place)	Date		c. Location - City or	
Ē	Pages ment of ent: If its ury or o		1 ➡ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			metery 7	/29/0	5 D€	etroit M	ich
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service License	Muse	m	Ster	nd Address of Facility ling Fund	eral	Servi	ce	
			23a. Parl 1. Enter 14 diseas and omp	cations that caused	the death. Do r	POB not enter the mo	617 Ster ode of dying, such as	ling_cardiac or res	Va_201 spiratory arrest	167	Approximate
	Physician		shock, or failure st only on immediate C (Final disease or condition resulting in death)			BREAST (Interval Between Onset and Death
	/Medical		resulting in death)		consequence		DANOLK				Years
	Examiner	10	Sequentially list conditions,	. — Due to for as a	consequence	of):					
	ned I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due 10 (0) as a	Consequence	017.					
Š	ate be executed nysician and he burial-transit		resulting in death) Last	Due to (or as a	consequence	of):					
8/60,	cate be physici the bu	dlcal									
89 X	leath certificate attending phy I for use as the	/Me	IF FEMALE: 2	3c. If yes, outcome of	of pregnancy					23d. Date of del	livery
. Box	death e atter id for u	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No	1 Live birth :		3 ☐Ectopic 5 ☐ Other (Month	Day Year
J Ö	at the de t by the stached	Phys	9 Unknown	9□ Unknown					00 - 01111		
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	l by	Part II. Other significant conditions con	ithbuting to death bu	it not resulting ir	n the underlying	cause given in Part I.				o the cause of death? robably 4 Unknown
Hecords,	w requ	letec							24a. Wasan		utopsy findings available
	The lav	Completed							autopsy performe 1 Yes 25	prior to death?	completion of cause of
VItal		BeC	25. Was case referred to medical examiner?					of Death (CI	neck only one)	QIIIO	
	Physic this ce al dire	2	1 ☐ Yes 2 ₹ No	lospital: 1 Inpatie						ce 6 Other (Spe	cify)
- -	ding F h. After funer	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ I		Describe now	injury occurred	
Division of	l or Attending F after death. Director: After I in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	iry - At home, fa	arm, street, facto	ory, office		Location (Stre	et and Number or Ru State)	ural Route Number,
	itel or irs afte rel Dir led in	Cert									
	To the Hospitel or Attending Physiciem: within 24 hours after death. To the Funerel Director: After this certific completely illied in by the funeral director.	edical	29a. Certifier 1 \(\bigcite{\text{M}}\) Certifying Phys (Check only one) 2 \(\bigcite{\text{M}}\) Medicel Exemination	sician: To the best oner: On the basis of and manner sta	examination an	e, death occurre nd/or investigation	d at the time, date and on, in my opinion, deat	d place, and th occurred a	due to the caus t the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and mainer sta		2	9c. License number		290	. Date signed (Mont	h, Day, Year)
			120 W	Zell	AN	10	0101233383			TUL, 29	5, 2005
0	(5)		30. Name and address of person who co			(Type, Print)				AL CENTER	
	- C	10	DRAKE H. TILLEY 31. Date filed (Month, Day, Year)	■ Registra	SN nr's Signature		BETHESDA	MD 20	889 - 56(JU	
2	Sta Regist		JUL 2 7 2005	Bloom	N A	porte					

Physician /Medical	State Registrar 1. Decedent's Name (First, Middle, Last) VIRGIA INEZ PIPPE			medie on i	Death		Reg. Ne	5 26275
	ATKGIN INEV PIPPE					2. Date of De Month July 2	ath Day	3. Time of Death
	4a. Facility Name (If not institution, give s Prince George's H	street and number) lospital		4b. City, Town, or Cheverly	У	ith	4c. County of	Death e George's
Director	5. Social Security Number 577-16-9500 Usual Residence of Decedent	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hr. Hours Mir	(Month, Da	th y, Year) 3, 1911	9. Birthplace (State or Forei Country) Florida
Ba-fehow offitted at ector	Maryland Prince Ge 10e. Street and Number		y, Town or Loca Idensbui	rg				10d. Inside City Lim 1 X Yes 2 ☐ I
23a or	5408 Tilden Road	12. Was Decedent Ever in U. Armed Forces?	S. 13. Wa	10f. Zip Code 20710 as Decedent of Hires, specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or No	U.S.A. 14. Race Black,	- American Indian, White, etc.
natural, or i	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	1 ☐ Yes 2 M No If Yes, Give Year or Dates:	16a. Decede	Yes 2 No	Specify:	ortrina	Specify:	White iness/Industry
Hygiene Hygiene ther than "natura int, the Medical is Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Homema	nd of work done of NOT use retired			Own Hot	
3 <u>a</u> b s a s	Jay Lemeul Foreha 19a. Informant's Name/Relationship (Ty)		19b. Mailing	Address (Street a	Pauline	Weaver	er, City or Town, S	
Health tem 27 is other tra	Betty Anadale - D 20a. Method of Disposition 1 ☑ Burjal 2 □ Cremation 3 □ R	20b. P	6908		d, Glen		aryland 2 20c. Location - C	20769
E 8 3	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		22.1	In Cemete Name and Addres	s of Facility	Gasch's	Funeral H	d, Maryland Home, P.A. MD 20781
ysician	23a a 11. Enter he disease, or mild shock, or heart failure. List only in mind the Cause (Final disease or condition resulting in death)	cations that caused the death ne cause on each line. Small Bowel	n. Do not enter	the mode of dying				Approximate Interval Between Onset and Death 6 days
mand tial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
ding se a:	IF FEMALE: 2 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 E	ctopic pregnancy Other (s <i>pecify</i>)			23d. Date Monti	,
bed bed	Part II. Other significant conditions cor Metabolic Acidosi		ulting in the und	erlying cause give	en in Part I.			ute to the cause of death
ate has page 2						24a. Was autop perfo 1 Yes	osy pri ormed? de	ere autopsy findings availa or to completion of cause ath? Yes 2 \(\text{No} \)
φ 5 0	25. Was case referred to medical examiner? 1 □ Yes 2 XNo	lospital: 1 🛣 Inpatient 2 🗆	EB/Outnationt	3□ DOA Othe		eath (Check only o	one) dence 6 □Other	(Specific)
After th funeral	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		_	how injury occurred	
24 hours after death • Funeral Director: letely filled in by the cdical Certifical	4 Homicide determined	28e. Place of tnjury - At ho building, etc. (Specify	()		a data and place	City or Tov	wn, State)	or Rural Route Number,
within 24 hours a	(Check only 2 Medicel Examir	sician: To the best of my knowner: On the basis of examinal and manner stated.	tion and/or inve	stigation, in my or	pinion, death occ	curred at the time,	date and place, an	d due to the cause(s)
To the complete	29b. Signature and title of certifier	Clt.	ИО	29c. License			29d. Date signed	
(10)	30. Name and ad ress of person who co Miche (A. Schw	mpleted caus of death (Item or E, W) 7 Registrar's Signa	1 23a) (Type, Pr	int)	Clay	1304,6	reensel	7, MA 2077

				State of M	laryland	•	artment <i>rtificate</i>			and M	_	00	0.5	20	076
			Decedent's Name (First, Middle, L.)	ast)			inicate	01 1	Juan		2. Date of De	Reg. No.	U.J	7 Tir	me of Death
	Physic /Medi		Kevin	Perry							July 2	22, 200			2:25PM
)	Exami	ner	4a. Facility Name (If not institution, gi	~ 15.				4	•		cation of Deat		ty of Death		
			St. Thomas Moore				If Under	1 Voor	Hyat If Under	tsvi	lle	Pri	nce G	eorg	es
	Funeral Director		577-06-6286	18 M 2□ F	ge (In yrs. la 3	Yrs.	Months	Days	Hours	Min.	Feb.	1968, 1968	Wash	ntry) ingt	on, DC
	and *		Usual Residence of Decedent 10a. State 10b. County	<u> </u>	10c. City.	Town or Lo	ocation		_						de City Limits
	daryl f sho	ō	DC			ningto									Yes 2□No
	the the table	rect	10e. Street and Number				10f. Zip (Code		-		10g. Citizen o	if What Cou	ntry?	
	with with	Ö	928 T Street N	الم				0001					d Sta	-	
	Jeath Tre 2:	era	11. Marital Status	12. Was Decedent	t Ever in U,S	. 13.			spanic Ori	gin? (Spe	ecify Yes or No		ace - Ameri		an,
21215-0020	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: if item 27 is marked other then "netural", or items 23e or 28a-f show important: if item 27 is marked other then "netural", or items 23e or 28a-f show hipty or other traumatic event, the Medical Examinat must be nutified at ONCE.	by Funeral Director	1 🕏 Never Married 2 🗍 Married 3 🗆 Widowed 4 🗆 Divorced	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	? No		lf Yes, speci 1 ☐ Yes 2			, Puerto	ecify Yes or No Rican, etc.)	В	lack, White, ^{cify} Blac	etc.	
ŏ	2 hou	8	15. Decedent's E	ducation		16a. Dece	dent's Usual	Occupa	ation			16b. Kind of			
215	hin 7.	Completed	(Specify only highest gi	rade completed) College (1-4or	54)	(Give life.	kind of work DO NOT use	k done a e retired	luring mosi)	t of worki	ing			•	
21	d with giene.	ĕ	10th	College (1-40)	34)	Disal	ble					Disab	led		
	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Las	t)					18. Mothe	r's Name	(First, Middle	, Maiden Sum	ame)	-	
<u>la</u>	Mental Merked of artic eve	10 E	Joseph N. Perry						Dar	lene	McC1	inton			
Maryland	2 should end Men is marke	-	19a. Informant's Name/Relationship	(Type, Print)			-				d Route Numb				
	1 end 2 Health e em 27 is		Joseph N. Perry	/ Father		401	K Str	reet	NW #	709	Washing	gton, [C 200	01	
Baltimore,	of He of Herr		20a. Method of Disposition 1	7D	20b. Pla	netery, crea	osition (Name	e of her place	e)		Date	20c. Locatio	n - City or To	own, Sta	te
Ĕ	Pag nent Iny o		4 □ Donation 5 □ Other (Spec	-	,		on Nat			m.	7/27/0	5 Sui	tland	, Ma	ryland
alt	permit. Pages 'Department of Himportant: if ite eny injury or ot once.	1	21. Signature of Funeral Service Lice	nsee /		22	2. Name and	Addres	s of Facilit	y Eun	eral H	ama.			
Ω	88 5 8		17-6	2/1							W Wash		DC 2	0011	
			23a. Part1. After the disease, or conshock, or heart failure. List only	nplications that cause	d the death.										kimate Il Between
-1	Physician		Shock, of heart allule. List only	one casea on ear	mile.	-							1	Onset	and Death
1	/Medical		Immediate Cause (Final disease or condition	Hur	2020	In	m	no	do	1:00	ency	dise	000	1	Veax
	Examiner		resulting in death)	a	Due to (or	as a consec	quence of):	210	ay	14	- College	2(100	070	/ '	100
	ם ≃	ner		8.					U						
	requires that the death certificate be executed seen signed by the ettending physicien and hould be deteched for use es the buriel-transit	Examiner	Sequentially list conditions,	D	Due to (or a	as a consec	quence of):								
ó,	e exe	<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										1		
8760,	ete b hysic the b	dlcal	that initiated events resulting in death) Last	G.	Due to (or a	as a consec	quence of):								
9	ing p	Ž.		d											
Вох	es thet the death certific igned by the ettending p be deteched for use es	Physiclan/Me		u.											
o.	e de the e	sic	Part II. Other significant conditions	contributing to death t	out not result	ting in the u	nderlying ca	use give	n in Part I.		23b. Did	tobacco use	ontribute t	o the car	use of death?
<u>G</u>	d by detec	됩	Mullinga	an Ho	0 0/c	INE	2				1 🗆	Yes 2□ No	3 ☐ Pro	bably	4)X Unknown
JS,	res the	ର୍ଲ	1. 401009	aciye									T		
Records,	v require been si should I	Completed		\mathcal{O}							24a. Was perfo	an autopsy rmed?	av	ailable p	psy findings prior to n of cause
Sec.	S E	효											of	death?	, 01 02000
		ខ	No.								10	Yes 2 KNo	1[☐Yes	2□ No
/ita	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	At				011		of Death	(Check only o	one)			
of Vital	Physician: this certific ral director,	ဥ	1 ☐ Yes 2 M	Hospital: 1 ☐ Inpati		R/Outpatier			4500110		me 5□Resi			(y)	
Division	5 <u>5</u> 5	Certification:	27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Inju (Month, Da	ay Year)	28b. Time o injury	M 28	c. Injury Work 1 □ \	at ? /es 2∐1		28d. Describe	how injury occ	urred		
Vis	Atter or dea ector by th	Hice	3 Suicide 6 Could not I	200. Place of in	jury - At hom	ne, farm, str	eet, factory,	office	-	2	28f. Location (Street and Nur	nber or Rura	al Route	Number,
ă	To the Hospital or Attendil within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Cert			tc. (Specify)	/ 100 100		7.157.15			City or To				
	n 24 hc	edical	29a. Certifier (Check only one) 1 Scertifying P. 2 Medical Exa	hysiclan: To the best miner: On the basis o and manner s	of examination	eage, death on and/or in	n occurred al vestigation, i	tne tim in my op	e, date and inion, deat	piace, a	and due to the ed at the time,	cause(s) and i date and place	nanner as s e, and due to	tated. the cau	use(s)
	Withii To th	ž	29b. Signature and title of certifier	_			29c.	License	number			29d. Date sign	ed (Month,	Day, Ye	ar)
			Kaluan	(ao.	•			1/9	600	7.	-	7.22	05		
	3		30. Name and address of person who	completed cause of	death (Item 2	23a) (Type,	Print) Z	5/	30	on.	1, 01-	-1001-			
				uier,	MI	20	712		110	- 38	7 31	y cel			
	Sta	-	31. Date filed (Month, Day, Year)	32 Regist	rar's Signatu	re de	all								

DHMH 16 Rev 6/95

		,	1 - For State Registrer	State of Marylar	nd / Depa		Health and N	Mental Hy			262	77
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath		3. Time of I	Death
	Physicia /Medic		Mildred G			Roth		July	25 ^{Day}	2005	8:15	PM
	Examin		4a. Facility Name (If not institution, give			7.	or Location of Death		1	ounty of Death		
		>	Wicomico Nursi	_	4-11-4-6-1		isbury	1 - 5 · · · (5)		comico		
	Funeral		5. Social Security Number 6. Se 215-38-1479	x	. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da	v Yearl	9. Births	place (State or	r Foreign
	Director		Usual Residence of Decedent	04				Feb. 3,	1941	Mary	Land	
	ylanc how		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	0d. Inside Cit	
	e Ma	cto	MD Wicomico)	Sharpt	own					1 🗌 Yes	2 <u>X</u> No
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Cou	ntry?	
	s 23a	ral	5636 Galestown Rel		10 110		861	77.37		USA		
\	ter de Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No	J.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	oecify Yes or No Rican, etc.)	14.	Race - Americ Black, White,		
38	ours after death with the Marylar ral', or Items 23a or 28a-f show Examiner must be notified at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠ No	Specify:		Sp	pecify:	White	
700	72 hours netural', dical Exa	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16a. Dece	dent's Usual Occup	pation	kina	16b. Kind	of Business/In	dustry	
22	Ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of work ad)	vii ig				
72	filed within 72 hours after death with the Maryland Hygiene. kther than "netural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at		12		Keypu	ınch Oper		(F) . M(()		puter		
land	d la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last)	**			18. Mother's Nam		Maiden Su			
20	d 2 should be filed within th and Mental Hygiene. 7 Is marked other than traumatic event, the M	J.	John R 19a. Informant's Name/Relationship (T	Horney		na Address (Street	Mildred		r City or T		Lewis	
Z S			John R. Horney, Ji	•			arptown,			own, olato, zij	0000	
	~ ¥ 2 ±		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other pla		Date 2100		tion - City or To	own, State	
- E			1 ☐ Burial 2 ☐ Cremation 3 ☐ I 14 ☐ Donation 5 ☐ Other (Specify,	Removal from State			arva 7/27	/2005	De 1ma	r, Del	aware	
alti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licens			2. Name and Addre		Sounds F			aware	
<u> </u>	88 = 8		1//llson kg	Herry	7	05 E Mai	n Street	Salisb	ury, l	MD 2180	4	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea one cause on each line.	nth. Do not ent	ter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition	a FAILURE	To	THRIVE					Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	7		_				
*		-F	Sequentially list conditions,	b. VIETASTATIO	C /	SPEAST	AN	CER				
	uted J Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		4401100 01/1					- 1		
ć.	te be executed ysicien and ne burial-transit	Exa	resulting in death) Last	Due to (or as a conse	quence of):			-				
760,	# × a	cai		d								
89	leath certificat attending phy I for use as th	Medi	IF FEMALE:									
Вох	ath ce ttendi or use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	al death 3[Ectopic pregnanc	ry .		230	d. Date of delive Month		'ear
o.	ne deg the a	/sici	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5□	Other (specify)				WOTET	Day	oui
P.O.	that the di ed by the detached		Part II. Other significent conditions co	entributing to death but not re	sulting in the u	nderivina cause an	ven in Part I.	23e. Did to	obacco use	contribute to t	he cause of de	eath?
ds,	w requires to been signer should be contact.	d by	URINARY TRA	1 -	ectio			10	res 2□t	No 3□Prot	ably 4XU	Inknown
100	w req	lete	ANOIZEXIA					24a. Was	an 2	24b. Were auto	psv findings a	available
Re	The lav	Completed	· 1100/26 / /11					autop	rmed2	prior to co death?	mpletion of ca	
ital	en: Trifical	0	25. Was case referred to medical				26. Place of Dea	th (Check only o	2 X No	1 🗆 Yes	2/10	
>	nysiclen: nis certific director,	ToB	examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Ott	her: 4 XNursing H	ome 5 🗆 Resid	dence 6	Other (Specif	y)	
0	d ing Ph y h. After thi funeral o		27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	rk?	28d. Describe I	now injury o	ccurred		
sio	tendl leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No	00(1) 11 (1)	7			
Division of Vital Records,	or At after of Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, str hify)	reet, factory, office		28f. Location (3 City or Tox		lumber or Run	u Route Numb	⊅⊖ <i>r</i> ,
	To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours efter death. To the Funerel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	ledical Co	(Check only @ Medical Exem	vsician: To the best of my kn iner: On the basis of examin	nowledge, deat nation and/or in	h occurred at the ti	ime, date and place opinion, death occur	, and due to the rred at the time,	cause(s) an	nd manner as s	tated. o the cause(s))
	thin 2 the orthe	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen:	se number		29d. Date s	igned (Month,	Day, Year)	
	T × T o		Male. 1	1.11.	115		- min	515	71	Silve		
	OB		30. Name and address of person who c	completed cause of death (Ite	em 23a) (Type	Print)	www	112	-4	16 PL)	
	10		Mahesha Thimma	rayappa 614			e Dr Sa	lisbur	y MD	21804		
	Sta		31. Date filed (Month, Day, Year)	32. Raistrar's Sign	nature	1						
	Registr	ar	00L4 0 6	UUJ MARIE	1. 1	mark. 5						

			1 For	State of Ma	ryland / Depa				A A -) ET	2020			
			Registrar 1. Decedent's Name (First, Middle, Last)		Cel	rtificate of L	Jeath	2. Date of Dea	eg. N2 0 0	13	3. Time of Death			
t	Physici		John Herbert R	uhl. Jr.				Month	1, Day 2005	Year	2:45 pm ^M			
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of De		4c. County	of Death	2.45 Pm			
	٠,		316 Church Ct.			Westmi	nster		Carr	roll				
	Funeral		5. Social Security Number 6. Sex	M 2DE	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Day	Year)	Count	ace (State or Foreign			
	Director		213-58-1903	5	55 Yrs.			Dec 5,	1949	New	Jersey			
	yland yland		10a. State 10b. County		10c. City, Town or Lo	cation				10	Od. Inside City Limits			
	a-f st	ctor	Maryland Carroll		Westm:	inster					1⊠Yes 2 No			
	or 28	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	/hat Count	ry?			
	s 23a		316 Church Ct.	0 W - D		2115		10 11 11	USA					
	ter de	Funerai	11. Marital Status 13 Narried 2 Married 2 Married	 Was Decedent E Armed Forces? 1 ☐ Yes 2 XN 		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		e - America k, White, e				
036	ursal al', ou Exam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1☐ Yes 2XNo	Specify:		Specify:	Whi	te			
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade		16a. Dece	dent's Usual Occupa	ation during most of w	vorkina	16b. Kind of Bu	siness/Ind	ustry			
121	within ine. ihan	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	life.	DO NOT use retired)		7DC		л			
2	filed v Hygie other f	e Co	12 17. Father's Name (First, Middle, Last)	0	Pr	oduction		ame (First, Middle, I	ARC and		L			
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. It marked other than "natural", or items 23a or 28a-f show umatic event. Ire Madical Examiliar must be notilled at	To Be	John Herbert Ruhl	, Sr.				ces Veron		,	У			
lary	2 sh and is m		19a. Informant's Name/Relationship (Typ Kathleen Haines	e, Print) niece	19b. Mailir	ng Address (Street a Church Ct		Rural Route Number			Code)			
	1 and 1 eaith 9m 27 ther tr		20a. Method of Disposition	litece	20b. Place of Dispo		• Wesu	minster, I	20c. Location - 0		um Cinto			
nor	ages int of 1 t: If its		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	moval from State	cemetery, crei	natory or other place Cremation	-		Hampstea	-				
altimore,	permit. Pages 1 and Department of Healinportant: If Item 2 any injury or other once.	. 7	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensee			. Name and Addres								
ñ	Depar Depar Impo any ir		I John K By	el			P.	. Westmin			Chapel, PA 157			
			23a. Party Enter the disease, or complic shock, or heart failure. List only one	ations that caused to cause on each line	the death. Do not ent	er the mode of dying	g, such as cardi	ac or respiratory arr	est,		Approximate Interval Between			
2	Pnysician	í (i	Immediate Cause (Final disease or condition	P	rognessi	K New	rologi	c Ded	ine		Onset and Death			
	/Medical Examiner		resulting in death)	mediate Cause (Final lease or condition sulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
		e.	Sequentially list conditions, if any, leading to immediate			-								
	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
Ö,	cate be executed bhysician and the burial-transit		resulting in death) Last	Due to (or as a	consequence of):									
8760,	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d.											
9 ×	leath certific attending p	by Physician/Me	IF FEMALE: 23	c. If yes, outcome o	f pregnancy				22d Date	of deliver				
Вох	death a atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 4 Pregnant at t	Petal death 3 ☐	Ectopic pregnancy Other (specify)			Mon		y Day Year			
<u>о</u> .	t the c by the	hysi	9 Unknown	9□ Unknown										
	res that the de signed by the a be detached f	by P	Part II. Other significant conditions control	ributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.				a cause of death?			
ord	w require been sly should b		Hy pothy re	1 di Sin				1 🗆 Ye	s 2 Mo	3 🗌 Proba	bly 4 🗆 Unknown			
Records,	has b	Completed	deizure	to strake	/			24a. Was a autops perforr	n 24b. W	ere autop:	sy findings available pletion of cause of			
_								1 □ Yes 2	2 No 1	eath?	2□ No			
Vita	yaician: is certific director,	o Be	25. Was case referred to medical examiner?	spital:	t 2 ☐ ER/Outpatien	A 2C DOA Othe	ar	eath (Check only on	*					
0	g Phy er this eral d	300	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury	at	Home 5 eside						
Ö	anding lath.	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Work M 1□1	r? ∕es 2 □No							
Division of	or Attan ifter deat Director: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (St City or Town	reet and Numbe , State)	or Rural	Route Number,			
	pital o		000 00000000000000000000000000000000000											
	To the Hospital or Attanding Physician: which 24 hours after deals at the full of the Funeral Director. After this certifical completely filled in by the funeral director, it	Medicai	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examine	cian: To the best of er: On the basis of and manner stat	examination and/or in	roccurred at the tim vestigation, in my op	e, date and place inion, death occ	ce, and due to the ca curred at the time, di	tuse(s) and mar ate and place, a	nner as sta nd due to t	ted. the cause(s)			
	To the within To the complex c	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed	(Month, D	ay, Year)			
ł	3		James X	Frskas	6	23	3561		7-2	2-0	S			
	サヤ		30. Name and address of person who com	pleted cause of de	at (Item 23a) (Type,	Print)	- 4	41	0 7	70,1	1			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar		s way 411	TICIA	Mitung, 1	MU XI	157				
	Registr		JUL 2 2 200		n & s	hade								

		-	_ State	eartment of Health and Meartificate of Death		giene Reg. N 2 0 0 5	26279
	التسع		Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month		3. Time of Death
	Physicia /Medic		IVAN WESLEY RE	CAVER	JULY 2	22, 2005	8:25 P M
I	Examin		ta. Facility Name (If not institution, give street and number) LOOKABOUT MANOR	4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 152 M 2□ F 7. Age (In yrs. last birthday 1. Age (In yrs. last	y If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day 10/2/	r, Year) Cou	place (State or Foreign untry) YLAND
	pu *		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or L	ocation			10d. Inside City Limits
	daryla f sho	ō		INSTER			1 ☐ Yes 2 X No
	r 28e-	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	untry?
	th with		1510 STONE RD.	21158		USA	
36	be filed within 72 hours after death with the Maryland ntal Hygiene. So other than "neturel", or Items 23e or 28e-f show event, I're Medical Evand or must be notified at event, I're Medical Evand or must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates: ₩₩ ፲ ፲	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto f 1 ☐ Yes 2 X No Specify:	cify Yes or No- Rican, etc.)	0	
9	2 hou	ted !	15 Decedent's Education 16a, Dec	edent's Usual Occupation e kind of work done during most of working	na	16b. Kind of Business/l	ndustry
aryland 21215-003	within 72 tiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) CARPENTI		HOME IMPR	OVEMENTS
d 22	filed w Hygier other tl		8 17. Father's Name (First, Middle, Last)	18. Mother's Name			OVERTENTS
au	Ald be fental riked o	To Be	JOSEPH MILTON REAVER	, SR. DORTHY	MU	MMERT	
lary	s 1 and 2 should be f Health and Mental item 27 is marked other treumatic ev	-		ling Address (Street and Number or Rura			
e,	s 1 and sift Health item 27 other tr		DENNA MILLER - DAUGHTER 340 20a. Method of Disposition 20b. Place of Disp	McSHERRY WOOD D	OR • , LLL'I	L'TLESTOWN 20c. Location - City or	
nor	0 0		MRusial 3 Compation 3 Deproyal from State cemetery, cri	ematory or other place) 7/26 N CHURCH OF GOD	6/05 CEM.	FINKSBURG	. MD.
Baltimore,	permit. Pag Depertment Importent: I any injury o		21. Signatury Funeral S. once Licensee	22. Name and Address of FacilityFLET	rcher	FUNERAL H	OME
	-		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or freat failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	cu			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a con) equence of):	sentudius Pu	hmon		25tm
		jer	Sequentially list conditions, Thry Leading terms data cause. Enter Underlying	1	,	any Disas	2370
	ocuted nd transit	Examiner	Cause (Disease or injury that initiated events c.	i Hent Far	Unic		5 yrs
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Вох	death certific e attending p ed for use as	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	Ectopic pregnancy		23d. Date of deli Month	very Day Year
О. Ш	D 0 0	ysicla		Other (specify)		Nonth	Day Foat
s, P.	law requires that the deas been signed by the 2 should be detached	by Physiclan/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	Щ.,	obacco use contribute to	
ord	w require been sig should b						obably 4 Unknown
Vital Record	0 4 6	Completed			24a. Was autor perfo 1 Yes		topsy findings available completion of cause of
ital	ilcien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death			
of V	tending Physicien: leath. tor: After this certific the funeral director,	ဥ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati			dence 6XIOther (Spec	ASSISTED LIVING
on	ding I th. : After funer	tlon	27. Manner of Death 1		200. 0000.100		
Division	or At fter c Direc in by	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (: City or Tox	Street and Number or Ru wn, State)	ıral Route Number,
_	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the ed at the time,	cause(s) and manner as date and place, and due	slated. to the cause(s)
	To Ihe To Ihe Comple	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month	
)	MJLIN		John W. Mulleton mo	D25443		7/25/20	105
	5+ IVA		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	Nest	sol - M	のシェラ
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2 6 2005	e, Print) Legg Pack Road, V	-J/M	MISIET	
	negisti	rui	00 L 10 L 1000 JOHN JO	MINICAL			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Z 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 ear July **Physician** 20, 10:03AM Richardson Mary Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital
Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🔯 F Yrs. 85 577-22-5428 1919 Director Nov.7, Wash. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "neturel", or Itema 23a or 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Washington DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1244 G Street, 20002 NE Completed by Funeral <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiene. 7 Ie marked other than "ne Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12 Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked to any injury or other traumatic ever once. Alfred Douglas Lorretta Matthew 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10603 Terrapin Hills Court
Mitchellville, Maryland 20721
e of Disposition (Name of 2000) 10603 Jerome Richardson/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cem. 7/27/05 Suitland, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 nuce 23a. Pay 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme te Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-trar attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2V No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? END STAGE RENTAL DISTASE, SACRAL PRESSURE SORE 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown INFECTION, ATRIAL FIBRILLATION, ANEMIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has MALNUTHINON HYDELTENSION WITH SHOCK. 1 Yes 2 ₩ funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 2Ba. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death 28b. Time of After 1 or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 | Homicide within 24 hours a To the Funerel C To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified -suyan sunea D53367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAITHERSHUNG, MD: 20878. ROAD, SUITE: 202 DARNESTONN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 27 2005

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 4:07 PM VINCENT ALFRED RICHARDSON JUL 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1⊠M 2□F 78 Director 023-16-0842 May <u>Massachusetts</u> Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examinar must be notified at 1X Yes 2 No Director PRINCE GEORGE'S GLENARDEN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 20706 U.S.A. 1505 1st STREET or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 □ No ARMY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1972-Specify: Specify δ 3 ☐ Widowed 4 ☐ Divorced 'natural', Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) POLICE OFFICER GOVERNMEN T and Mental Hygie is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any linky or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MABLE RICHARDSON FRANCIS LATTIMER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1505 1st STREET GLENARDEN, MARYLAND 20706 DOROTHY RICHARDSON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON NATIONAL 8/25/05 ARLINGTON, VIRGINIA * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service License 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MASSIVE PULMONARY EMBOLUS /Medical Due to (or as a consequence of) Examiner STAGE IIIB NON-SMALL CELL LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2√2 No 24a. Was an autopsy perform certificate 2**[**] No 1 Yes 2 💢 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 📉 No Other: ٥ 1 🔀 Inpatient 2 EP/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation **X**Natural 1 □ Yes 2 □ No after death. Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D 29a. Certifiei 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number Date signed (Month, Day, Year) 29b. Signatu 12,2005 00024029 (AL) dress of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDIÇAL 30. Name a JOHN \$ THURBER CDR MC USN BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUL 2 7 2005 Registrar

			1 - For State Registrar	State of Marylan	•	artment of F		ind Menta	al Hygier Reg. 1	0000	26282	
			Decedent's Name (First, Middle, La	st)			-		te of Death		3. Time of Death	_
	Physicia /Medic		Helen E	lizabeth		Ryan		Ju1	y 23,	2005	8:55 A M	
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of		-	c. County of Death		
			19907 Silverfiel	d Drive		Montgome	ry Vil	llage		Montgome	ry	
	Funeral		5. Social Security Number 6. S	DM 200E		If Under 1 Year Months Days	If Under 2 Hours	Min. (Mo	e of Birth onth, Day, Yea	ur) Cou	place (State or Foreign intry)	3
	Director		059-20-2433 Usual Residence of Decedent	81	Yrs.			Ju1	y 7, 1	924 New	York	
	and and		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits	-
	Mary faho	jo	Maryland Montgom	ery Mon	tgomer	y Villag	e				1⊠Yes 2□No	
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. (Citizen of What Cou	intry?	_
	h with	a D	19907 Silverfield	Drive		20	886		U	nited Sta	ates	
	ould be filed within 72 hours after death with the Maryland Mental Hygien. arked other than "natural", or items 23e or 28e-f ahow atic event, the Medical Examinal must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		Was Decedent of H	lispanic Orig	gin? (Specify Ye	es or No-	14. Race - Amer Black, White		
0	or its		1 ☐ Never Married 2X Married	1 ☐ Yes 2X No If Yes, Give		1 □ Yes 2⊠ No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	Specify:		
200	urai',	d by	3 Widowed 4 Divorced	Year or Dates:	10. 5				1.00	W	hite	
<u> </u>	n 72 "nat	Completed	15. Decedent's E (Specify only highest gra		(Give	dent's Usual Occup kind of work done DO NOT use retire	ation during most d)	of working	160.	Kind of Business/li	ndustry	
7	withi ene. than	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)		memaker	-/			Own Home		
5	Hygi other ent,	Be C	17. Father's Name (First, Middle, Last,)			18. Mother	r's Name (First,				-
alla	lic ev	To B	George Schultz				Midi	Kapp				
ary	2 should be and Mental is marked of raumatic eve		19a. Informant's Name/Relationship (** *							p Code) 20886	
Z Z	and 2 alth a		Joseph C. Ryan/Hu	sband	19907	Silverf	ield D	Orive, M	lontgom	ery VI11a	age, MD	_
anımore	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic events.		20a. Method of Disposition 1 XBurial 2 Cremation 3	20b. F	lace of Dispo emetery, cre	osition (Name of matory or other place ington	ce) A	Date August 1		Location - City or T	own, State	
Ē	Pag ment ant: I		'4 □ Donation 5 □ Other (Special	y) Nat	ional	Cemetery		2005	Arı	ington, V	/irginia	
<u>z</u>	ermit. epart nport ny inj nce.		21. Signature of Funeral Servi	11/	1	2. Name and Addre				_	MD 00077	
_	g0 = 9 9		MAN	MQ06						ersburg,		
			23a. Fart1. Unter the disease, or com shock, or hear failure. List only	one cause on each line.	h. Do not en	ter the mode of dyir	ng, such as o	cardiac or respir •	ratory arrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Colonic	, UC	lenoco	MU	roma	<u>ٽ</u>	8/20	03	_
	/Medical Examiner			Due to (or as a conseq	uence of):							
ш		er	Saquentially list conditions if any, leading to immediate	b. Due to (or as a conseq	uence of):							_
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	_								
'n	exection and trial-trial-trial	Exa	resulting in death) Last	Due to (or as a conseq	uence of):							
00/8	certificate be executed nding physician and use as the burial-transit	dical		_ d								_
0	rtifica ng ph as th	a)	IF FEMALE:									_
ŏ	tendi tendi	ian/M	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		☐Ectopic pregnanc	y			23d. Date of delive	rery Day Year	
	e death he atten ned for u	hysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5[Other (specify)				MORRI	Day real	
7	w requires that the death certific been signed by the attending p should be detached for use as	Phy	Part II. Dther significant conditions	contributing to death but not res	ulting in the	anderhijna eguse ein	on in Part I	23	le. Did tohaco	n use contribute to	the cause of death?	_
Š,	signe signe	l by	Tarring Street Significant Contaction of	sommeting to double but not not	aning in the c	indonying dadab gre	rom and divis		1 □ Yes	No 3□Pro		
ecords	requ	ompleted						-		^		
e E	e las has je 2	mp							 a. Was an autopsy performed? 		opsy findings available ompletion of cause of	,
	iician: The l certificate ha rector, page	O	OF INformation of the standard						Yes 2	No 1 ☐ Yes	2□ No	_
V II a	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 No	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outpatio	nt 3 DOA Ct	200	of Death (Chec rsing Home	(10)	6 □Other (Spec	4.1	-
		J	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injur	ry at		escribe how in		197	-
SION	nding th. r: Afte e fur	ation	Natural 5 Pending 2 Accident investigatio	(Month, Day Year) n	Injury	Wor M 1 □	rk? ∣Yes 2.∐.N	No				
SIS	Atte	ertificati	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, st	reet, factory, office		28f. Loc	cation (Street y or Town, Sta	and Number or Rui	al Route Number,	
5	rs after all Director	Cer		Building, etc. (opecn	,, 				, , , , , , , , , , , , , , , , , , , ,			
	t hou t hou uner	edical	29a. Certifier Certifying Pt	nysicien: To the best of my kno miner: On the basis of examina	wledge, deat	h occurred at the til	me, date and	d place, and due	e to the cause	(s) and manner as	stated. to the cause(s)	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fur e	Medi	one)	and manner stated.		29c. Licens				Date signed (Month		
	No o		29b. Signatur and title of certifier	Mulhan		Zyc. Licens	, manber	6	230. 1	7/2-/	2005	
-	20		MAINE	Cery MD	- 00-) 7	1000	063	129	1	1/20/	(10)	
			30. Name and ad ess of person who Carl Rudin, M.D.			•	ore. M	Maryland	21287			
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signa			, _,					-
		ar	1111 9 7 2	nor ZN	4 Ma	BARE B						

			For State Registrar	State of M	aryland	•	artment of H		_	giene Reg. No	2005	26283
H	Physicia	an	1. Decedent's Name (First, Middle						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Herbert 4a. Facility Name (If not institution		Carl		Ray 4b. City, Town, o	r Location of Dea	July	21	2005 County of Deat	8:30 P M
	Examin	er	500 High Bedfo:					erland			Allega	
-	Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. la	st birthday)	If Under 1 Year Months Days			th V Year)	9. Birtl	hplace (State or Foreign untry)
	Director		219-54-1344	1 ∑ M 2□ F	56	Yrs.	Mortins Days	110013 1911	06/08/19	949	Mary	
	and	1	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	f sho	io	MD A1	legany		Cı	umberland					1∭Yes 2□No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citi:	zen of What Co	untry?
	th with	al D	500 High Bedf	ord Street				21502		1	USA	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23a or 28a-f show or other treumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ed 1 NYes 2 If Yes, Give Year or Dates:	No No		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🗓 No	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No irto Rican, etc.)		4. Race - Ame Black, White Specify:	
8	2 hou	ted	15. Decedent	's Education	VIELI	16a. Dece	dent's Usual Occup			16b. Kir	nd of Business/	
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7	ad wit	Completed	12				Painter				ne Improv	rement
Maryland 21215-0036	be fill tal Hy od oth	Be	17. Father's Name (First, Middle,				T.		ame (First, Middle			D1:
3	should nd Men marke umatic	ဥ	Herbert 19a. Informant's Name/Relations	Dall	as	10b Mailie	Ray	Ida	Bural Boute Numb		ginia Town State 7	Blizzard
ā Z	d 2 st th and th and 7 Is r treur		Donna R. Ray / wif				E. Oldtown					
٠	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tre ance.		20a. Method of Disposition		20b. Pf	ace of Dispo	sition (Name of matory or other place		Date		cation - City or	
OE I	Pages ment of lant: If ite		1 🖾 Burial 2 □ Cremation 4 □ Donation → 5 □ Other (S)		١	-	. @ Rocky G		25/2005	Flir	tstone. I	Maryland
Baltimore,	permit. I Departm Importa any inju		21. Signature Fundal Service		LID AF	22	2. Name and Addre	ss of Facility	Adams Famil	Ly Fur	eral Hom	e, P.A.
m	Depar Impo		Kelet (· allera	~		404 Deca	tur Street	t, Cumberla	and, M	laryland	21502
г			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each I	d the death ine.	. Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	aFnd_Sta	oe Chr	onic Oh	structive	Pulmonary_	Disease			10 years
N.	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):		,				•
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	uted d ansit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
Ó	cate be executed physician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as	a consequ	ence of):				\wedge	_	\cap
8760,	ate be sysicia he bus	ical		d						7 ra	Q A	July 226
9	ing ph		IF FEMALE:	T								
Вох	death certifics e attending pt od for use as t	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pregnancy	1		2	23d. Date of deli Month	ivery Day Year
<u>.</u>	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant a 9☐ Unknown	it time of de	ath 5	Other (specify) _			1		
<u>α</u>	The law requires that the site has been signed by the bage 2 should be detache	/Ph	Part II. Other significant condition	ons contributing to death I	but not resu	iting in the u	nderlying cause giv	en in Part I.	23e. Did 1	obacco u	se contribute to	the cause of death?
ds,	uires n sign uld be								1 🗆	Yes 2	□No 3 🛛 Pr	obably 4 Unknown
00	w require s been si should b	lete							24a. Was		24b. Were au	topsy findings available
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Vital Record		Be C	25. Was case referred to medical					26. Place of D	eath (Check only			
of <	Physicien: r this certific ral director,	To	examiner? Released 1 X Yes 2 No	Hospital: 1 🗆 Inpati		R/Outpatier		4 🗆 Indiani	Home 5 🕅 Resi			cify)
n o	ing P		27. Manner of Death 1 Natural 5 Pendin		ury ay Year)	28b. Time o Injury	Wor	k?	28d. Describe	how injur	y occurred	
Sio	Attending ir death. ector; After by the fune	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be	iunt. At ho	ma farm at		Yes 2 □No	28f Location /	Stroot an	d Number or Ri	ıral Route Number,
Division	u or Attending P after death. I Director: After t d in by the funera	Certification:	4 Homicide determ	building, e	tc. (Specify)	reet, factory, office		City or To			mar rioute reamber,
	Hospite 4 hours Funere ely fille	edical C	29a. Certifier 1 \times Certifyin (Check only 2 \sum Medical one)	g Physician: To the best Examiner: On the basis of and manner s	of examinat	wledge, deat ion and/or in	h occurred at the til vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie	· A	1		A 29c. Licens	e number		29d. Dat	e signed (Monti	h, Day, Year)
11	1		1 Mohust	and /	1 da	ma	DOG	014865		July	22, 2005	j.
	IVA		30. Name and address of person	who completed cause of	<u>.</u>		Print)					
7	1 Ld			J. Barrera, N			morial Ave	nue, Cumbe	rland, Mar	yland	21502	
	Sta Regist		31. Date filed (Month, Day, Year)	2005 Heris	rars Signat	ure for	uli					

							artment of F		-		_						
		•	For State Registrar	Oldic	OI IIII		rtificate of		na monta		2005	26286					
			Decedent's Name (First, Midd.	e, Last)					2. Date Mor	e of Death	Day Year	3. Time of Death	_				
	Physicia /Medic		Mary	Shephe	rd			g 6, 20									
	Examin		4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death				4c. County of Death					
		*	Cumberland Vi 5. Social Security Number	lla Nursınç			Cumber If Under 1 Year		4 Hrs. 8 Date		Allegany	tholago (State or Cornigs	_				
	Funeral Director		214-05-7511	1 M 2 KF	93	In yrs. last birthday Yrs.	Months Days		Min. (Mor	of Birth nth, Day, Yea Q 10, 1	911	thplace (State or Foreign ountry)					
	ס		Usual Residence of Decedent						, , , , ,	9 .0, .	<u> </u>		_				
	arylar ahow	_	MD 10b. County	gany	1	0c. City, Town or L	berland										
	28a-f	ecto	10e, Street and Number				10f. Zip Code			100.4	Citizen of What C		_				
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23a or 28a-f ahow avant, the Modical Evaninar must be recitived at	Funeral Director	1500 C Oldtow	ne Manor	Ants			21502				· ·					
	death	nera	11. Marital Status	12. Was De		er in U.S. 13.	Was Decedent of H If Yes, specify Cuba		in? (Specify Yes	s or No-	14. Race - Am		_				
0	or Ita		1 Never Married 2 Mar	ried 1 Tyes	aive XNo		1 ☐ Yes 2 No	Specify:	r dello i licali, e	310.)	Specify:						
2-003d	within 72 hours after ene. than "natural", or Ita	d by	3 Nidowed 4 Divorced Year or Dates:			16a Dan	ident's Usual Occur			wnite							
<u>,</u>	in 72 "nat	oiete	(Specify only highe	nt's Education est grade completed		(Give	e kind of work done DO NOT use retire	during most c d)	of working	160.	. Kind of business	undustry					
7	d with giene. rr than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			Accou	ıntant			Tir	e and Ru	and Rubber Co. Sumame) In Town, State, Zip Code) MD 21555 Docation - City or Town, State mberland MD MD 21502 Approximate Interval Between Onsal and Death Saays I year					
and	be file ital Hyg id othe avant,	Bec	17. Father's Name (First, Middle,						s Name (First,		-						
yıa	should by od Menta	P.	Jack V.W. B						e (Witt)				_				
Mar	2 2 3 3		19a. Informant's Name/Relation: Donald Irons		ephe		ing Address (Street 16 Old Old			Idtown							
<u>ရ</u>	s 1 and f Health itam 27 other to		20a. Method of Disposition		<u> </u>		osition (Name of ematory or other place		Date								
Ē	Pages nent of int: If it iry or o		1 → Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		m State	Sunset Me		ce)	8/10/2	2005 C	umberlar	nd MD					
рашшо	permit. Pages 1 Department of H Important: If its any injury or ot once.		21. Signature of Funeral Service		11	1 - 2	2. Name and Addre	ss of Facility	al Home			y					
ם —	90 E # 8	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502)2						
			23a. Parti. Errer the disert e, o shock, or heart failure. Lis	r complications that t only one cause or	t caused the each line.	e death. Do not er	iter the mode of dyir	ng, such as ca	ardiac or respira	atory arrest,		Interval Between					
	Physician		Immediate Cluse (Final disease or condition resulting in death) a. Cere brovascular Accident 5days								5days						
	/Medical Examiner		resulting in assett)	Due t	o (or as a o	consequence of):	L.					1.20					
		-	Sequentially list conditions, if any, leading to immediate	b. Due t	consequence of):	TIC and	mry.	SVV		19tan							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			1.5											
Š	be executed ician and burial-transit		Due to (or as a consequence of):														
2/00	e i se	Jicai		d					-				_				
ρ X	certifica Iding ph	hysician/Med	IF FEMALE:	23c. If yes, o	outcome of	pregnancy					22d Date of de	livos	_				
X Q Q	death death e atten	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	у									
j.	the d by the	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk													
ທົ	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						236		Approximate Interval Between Onset and Death Soldards 23d. Date of delivery Month Day Year Duse contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify)						
ממ	equire en sis							-		1 Yes	2 No 3 P	robably 4 Unknown					
Hecord	law as b	ompleted							248	a. Was an autopsy performed	24b. Were a	utopsy findings available completion of cause of					
	Th ate pag	O								Yes 2	No 1 ☐ Ye	s 2 No	_				
VItal		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:] Inpatient	2 ER/Outpatie	ent 3 DOA Ott	16.7		eath (Check only one)							
ō		\vdash	27. Manner of Death		e of Injury	100					ijury occurred	эспу)					
0	Attanding ir death. actor: After by the fune	atio	E / tooldont	igation	Jilli, Day 1	ea <i>r)</i> Injury		Yes 2 □ No	lo								
UNISION		Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	nined 286. Pla	ce of Injury Iding, etc. (- At home, farm, s (Specify)	treet, factory, office		28f. Loc City	ation (Street or Town, St	and Number or F ate)	tural Route Number,	Ī				
	pital or urs afte aral Diu											_					
	To the Hospital within 24 hours a To the Funeral completely filled	edicai	29a. Certifier 1 Certifyi (Check only 2 Medica	Examiner: On the	he best of a basis of ea anner state	xamination and/or/i	th occurred at the te nvestigation, in my o	me, date and opinion, death	place, and due noccurred at the	to the cause e time, date a	n(s) and manner a and place, and du	s stated. e to the cause(s)					
	Fo the vithin Fo the complex	Me	29b. Signature and title of certific				29c. Licens				Date signed (Mon		-				
	> 0		▶ George He	nnawi, 1	10-	7/	- DOO	594	79	8	7/200	5					
	1		30. Name and address of persor			th (Item/23a) (Type		, 0	C A	0	7/200	_	_				
	14		George Henn	awi. 93	5 Bi	shop wa	Noh Ro	1, Wi	miserla	nd, M	02150	2	_				
	Sta Registr		31. Date filed Month, Day, Year AUG 1	1 2005	Selve .	J J A	porte										
				-			_										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:55 PM Clarine Sumner 20 2005 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hyattsville, MD Moore Thomas If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9-30-9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 227-32-1772 **Funeral** 1□ M 2 F -30-1 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show f Health and Mental Hygiene. Item 27 Is marked other than "naturel", or Items 23a or 28a-1 shov other traumatic event, If a Mudical Examene in the collision and Washington, 1 Yes 2 □ No DC Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5824 Eads 20019 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should ba filed within 72 hours after unent of Health and Mental Hygiene. ant: If item 27 Is marked other than "naturel", or Itel 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government ustodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ann Harris Yance Y John 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5824 Eads St NE, Wash, DC 20019 Sumner/Daughter Andrea 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 07/26/05 Landover, MD ational Harmonx 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joe Baltimore Funeral Home 1622 11th St NW, Wash, DC 20001 21. Signa vr-yet Funeral Service License complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, of shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final andis ascular VERIUSCH NOTE 1 RAS disease or condition resulting in death) Due to (or as a consequence of): f any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Completed by Physician/Medical Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) signad by the all 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? lag II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗆 No 1 Yes 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manne of Death Certification;

Physician /Medical Examiner

21215-0036

Baltimore, Maryland

The law requires that the death certificate be executed P.O. Box 68760. Records, Division of Vital To the Hospital or Attending Physiclan: Director: After this in by the funeral death.

after within 24 hours a completely

State

1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 - Homicide

29a. Certifier

(Check only one)

ical

28a. Date of Injury (Month, Day Year)

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Name and address of person who completed cause of death (Item 29o. License number

29d. Date signed (Month, Day, Year)

ORE

31. Date filed (Month, Day, Year)

JUL 2 8 2005

Registrar

			1 - For State Registrar	* -		d / Depa		lealth and	d Mental Hy	giene	0 =	26286		
	Physici /Medio		1. Decedent's Name (First, Middle Joseph	Arthur		S	lick			Day 25	Year 05	3. Time of Death 1505 PM		
	Examir Funeral	ner	4a. Facility Name (If not institution, PONINSULA LEGIO 5. Social Security Number	NM Medica 6. Sex 7. A	ed (INTA/ last birthday)	4b. City, Town, o	If Und 24 H	Hrs. 8. Date of Birth	<i>A</i>	9. Births	place (State or Foreign		
P	Director		169-26-4913 Usual Residence of Decedent 10a. State 10b. County	1 X M 2□F	71	Yrs. y, Town or Lo	Months Days	Hours M	lin. (Month, Day 2 11		Mary	land		
the Maryla	28e-f shor	Funeral Director		erset			s Anne			10g. Citizen		1 ☐ Yes 2 No		
ath with	23a or	ral Di	30530 Black Du	ck Lane			21	853		US.		,		
IIIQ X IX I 3-UU30 be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 23a or 28e-f show Important: If item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other traumatic event, the Macical Examinal must be inclined at once.		11. Marital Status 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 2 Yes 2 If Yes, Give Year or Dates:	? No		Was Decedent of H f Yes, specify Cuba I Pes 22 No	dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		USA 14. Race - American Indian, Black, White, etc. Specify: White ind of Business/Industry TO Parts Sumame) Or Town, State, Zip Code) Anne, Md. 21853 Docation - City or Town, State Lisbury, Md. Anne, Md. 21853 Approximate Interval Between Onset and Death			
D-C 2 hin 72 hc	an "natur Mactical	Completed by	15. Decedent (Specify only highes: Elementary/Secondary (0-12)		5+)	16a. Deced (Give life. L	lent's Usual Occup kind of work done DO NOT use retired	oation during most of i	working	16b. Kind of	3. Time of Death Year OS 3. Time of Death Year OS 1505 M Country of Death .			
illed with	Hygiene ther the	Сош	12 none Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle)											
Viario	Mental arked o	To Be	Joseph Hamilto						Rodgers					
Mar nd 2 sho	alth and 27 le mar r trauma		19a. Informant's Name/Relationsh Virginia Mae S			1				•	-			
Dallinore, Dermit. Pages 1 ar	ant of Hea nt: If item y or other		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp	3 □Removal from State	, a	lace of Dispo emetery, cren	sition (Name of natory or other place Memorial	ce)	Date	20c. Locatio	n - City or To	wn, State		
permit. F	Departm Importar any injur once.		Signature of Funeral Service 1	acensee .	MOO29	22	. Name and Addre	ss of Facility			-			
			3a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	Α Α	4	n. Do not ente						Approximate Interval Between		
1	Medical kaminer		disease or condition resulting in death)	aDue th (or as	s a consequ	7.5	Head	On my	5					
pe pe	sit	lner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	e as a consequence of).									
te be executed	/sician and e burial-trar	cal Examiner	Due to (or as a consequence of):											
OI VII TOO US, T.O. DOX OF Physician: The law requires that the death certifica	been signed by the attending physician and should be detached for use as the burial-transit	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year			
w requires that	an signed b uld be deta	by	Part II. Other significant containons continuously to death out not resulting in the underlying cause given in Part I.							2	Month Day Year co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?			
The law re	ate has bee page 2 sho	Completed	24a. Wa auto perf								sy prior to completion of cause of death?			
VIII.	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		55.0	Oth		Death (Check only or					
- 5º	ath. or: After this certificate has ne funeral director, page 2	-	1 Inpatient 2 EHOutpatient 3 DOA 4 Nursing Home 5 Residence 6 Dother (5									round		
To the Hospitel or Attending	within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could n 4 Homicide determine	ned 286. Place of in building, e	itc. (Specify 5 <i>C/L</i>	16/W	eet, lactory, office		LT 13	n, State) North	Salis	bury MD		
e Hosp	24 hou le Fune letely fil	edical	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best examiner: On the basis of and manner s	of examinat	wledge, death tion and/or inv	occurred at the ting restigation, in my o	ne, date and pla pinion, death o	ace, and due to the occurred at the time, o	ause(s) and i	manner as st e, and due to	ated. the cause(s)		
To th	To the comp	W	29b. Signature and title of certifier				29c. Licens	e number 4§ 7	2	1		Day, Year)		
			30. Name and address of person v				Print)					3		
			Howard Eily. 31. Date liled (Month, Day, Year)	100 E	ar's Signal	<u> </u>	St. So	lisbur,	y MD	21801	/			
	Sta Registr			2 2005	Seve-	N.	Such							

			1 - For State Registrar	State of Maryland	/ Depa		Health and	-	giene	•	26287		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 3. Arlene R. Sidman 3. July 26, 2005								3. Time of Death 8:30 P ^M		
	Examir		4a. Fecility Name (If not institution, give s 5225 Pooks Hill Ro	4b. City, Town, or Location of Death Bethesda Wontgomery If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthol					у				
	Funeral Director		5. Social Security Number 6. Sex 231-72-5109	7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days		Ain. 8. Date of Bir (Month, Date of Bir 20			hplace (State or Foreign untry) Smouth, VA		
	e Maryland Sa-f show	ctor	10a. State 10b. County MD Montgomer	y Beth	own or Lo					,	10d. Inside City Limits 1 ☐ Yes 2 X No		
	ath with th	Funeral Director	10e. Street and Number 10f. Zip Code 5225 Pooks Hill Road #922N 20814					10g. Citizen of What Country? United States					
39	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Items 23a or 28a-f show event, the Medicul Exarting minate incillish at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 	11	Vas Decedent of H f Yes, specify Cub I ☐ Yes 2∏ No	an, Mexican, Pu	? (Specify Yes or No uerto Rican, etc.))-	14. Race - Ame Black, White Specify: Wh	e, etc.		
21215-0036	ithin 72 hound.	Completed	15. Decedent's Educ (Specify only highest grade	College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)			working	16b. Kind of Business/Industry				
and 21	il Hygi other	Be	17. Father's Name (First, Middle, Last) Milton Jarl Becker			ntant		Name (First, Middle	, Maiden				
Maryland	nd 2 should be ilth and Mental 27 is marked or r traumatic ev	1	19a. Informant's Name/Relationship (Tyx) Howard Sidman, Son	pe, Print) 1			and Number or	**Rural Route Numb	er, City o	or Town, State, Z			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic as QDCB.		20a. Method of Disposition 12 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State 20b. Place	a of Dispos etery, crem	sition (Name of natory or other place	ce)	Date /28/2005	20c. Lo	ocation - City or			
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service License	Samely	11	Name and Addre	ss of Facility H Hampshi	ines-Rina re Ave Si	ldi lver	Funeral	Home, Inc. MD 20904		
	Physician /Medical		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Bone Marrow Fa	ailur		ng, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death		
	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence) Myelofibrosis Due to (or as a consequence)							17 Years		
8760,	cate be executed physician and the burial-transit	licai Examiner	d										
.O. Box 6	ath certifi ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Ectopic pregnancy Other (specify)	1		23d. Date of delivery Month Day Year						
σŽ	w requires that the de been signed by the a should be detached f	by	Part II. Dther significant conditions con	tributing to death but not resultin	resulting in the underlying cause given in Part I. 23					23e. Did tobacco use contribute to the cause of death' 1 ☐ Yes 2K2SNo 3 ☐ Probably 4 ☐ Unknot			
Records	The law te has b	Completed						24a. Was autoj perio	osy ormed?	prior to c death?	topsy findings available completion of cause of		
Vital	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		011		Death (Check only o	eath (Check only one)				
of	hys this at dia	. To	1 ☐ Yes 2 ☑ No	1 Inpatient 2 LEH/	Outpatient	t 3□ DOA Oth	4 - 14013111	g Home 5x Resi			cify)		
Division	ng ffe	Certification:	1 反 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Injury	28c. Injur Wor M 1 🗀		28d. Describe how injury occurred 28f. Location (Streef and Number or Rural Route Number.)						
Div	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		4 ☐ Homicide determined 29a. Certifier 1½ Certifying Phys	building, etc. (Specify) ician: To the best of my knowled	dge, death	occurred at the tir	ne, date and pla	City or To	vn, State	a) and manner as	stated		
	he Ho in 24 t he Fu pletely	edical	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	and/or inv	estigation, in my o	pinion, death or	ccurred at the time,	date and	d place, and due	to the cause(s)		
)	To t To t	Σ	29b. Signature and title of certifier	1/11		29c. Licens D433				te signed (Month			
	(0	l li	30. Name and address of person who cor Robert S. Siegel,			,	ne NW W	aghinoton	DC	20037			
	Sta	-	31. Date filed (Month, Day, Year)	32. Registrar's Signature		adi)							

			1 10						d Mental Hy		egible.		
		•	1 - For Stata Registrar		,	•	rtificate of l			Rag. NE	005	26288	
	Obvesiai		1. Decedent's Name (First, Midd	dle, Last)		-			2. Date of Dea		Yeer	3. Time of Death	
ľ	Physici: Medic/		George	William			Sigrist		July 29	, 200		7:40 AM M	
	Examin	er	4a. Facility Name (If not institution	-)		4b. City, Town, or				ounty of Deatl	1	
			700 Homewood 5. Social Security Number		ge (In vrs.	last birthday)	Pocomok If Under 1 Year				cester 9. Birth	nplace (State or Foreign untry)	
	uneral irector		215-36-1382	1 X M 2□ F	66	Yrs.	Months Days	Hours	Hrs. 8. Date of Birt (Month, Da)			untry) 1and	
ס			Usual Residence of Decedent		.,	T						10d. Inside City Limits	
lanyla	shov	5	10a. State 10b. Count			ty, Town or Lo						1 X Yes 2 □ No	
the N	28a-f	ect	MD Wo	orcester	Po	comoke	City 10f, Zip Code			10a. Citize	on of What Co	untry?	
with	3a or	Funeral Director	700 Homewood I	Orive			21851			-	USA	•	
death	ms 2	nera	11. Marital Status	12. Was Deceden	Ever in U	l.S. 13.			? (Specify Yes or No- ruerto Rican, etc.)		Black, White		
after	or Its		1 Never Married 2 Ma	arried 1 ☐ Yes 2 🔀	No	1	1 Yes 2 No	Specify:	55.15 / 1156.11 516.7		pecify:	, 610.	
S Poor	ture!	ed by	3 Widowed 4 Divorce			16a Dece	dent's Usual Occup	ation				nite	
5 nin 72	n "na de dic	plet		ent's Education lest grade completed) College (1-4or	E.\	(Give	kind of work done DO NOT use retired	during most of	working	100.11110	2 01 20311163371	ndustry	
d with	E Tha	Completed	Elementary/Secondary (0-12)	none	J+)	Owner	/Operator			Trucl	king Co	mpany	
Id be file	d other	Be	17. Father's Name (First, Middle	e, Last)				18. Mother's	Name (First, Middle,	Maiden S	y or Town, State, Zip Code) omoke City, MD 21851 Location - City or Town, State comoke City, MD		
at yilditid ZIZI3~UU30 should be filled within 72 hours after death with the Maryland nd Manta Hydiene.	arke atic	မ	John W. Sigris						e Shay				
Wical 12 sh hand	7 Is m traum		19a. Informant's Name/Relation John Taylor St										
an Healt	Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition	282200,000	20b. F		osition (Name of matory or other place		Date				
Pages	y or		*Surial 2 Cremation *4 Donation 5 Other	n 3 □Removal from State (Specify)	3		matory or other plac Cemetery	1	/01/2005	Pocor	moke Ci	tv. MD	
Daltimo	Importer any inju		1. Signature of Funeral Service				2. Name and Addre inman Fun		the first state of the contract of the contrac	1000.		,	
n 88	E 2 3		MINUS XX	enman 1	м0029					ess A	Anne, M	D 21853	
/M	sician edical	0	23a. Part1. Enter the Isease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or complications that a use st only one cause a each a. Due to a	line. 2011	th. Do not en	ter the mode of dyin	ng, such as car	Hicker	Test,	F 0	Interval Between	
fou, te be executed	been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, Tary leading to immunicular cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	DNE	54 DIJ	EN.	H						
The law requires that the death certifica		Physiclan/Med	Part II. Other significant conditions continuing to death but not resulting in the diluenying cause given in Part I.							23	23d. Date of delivery Month Day Year		
ecords, P	en signed b ruld be deta	by									ř	the cause of death?	
	ate has page 2	Completed								autopsy prior to completion of cause of death?			
Or VITAL	sertific ector,	Be	25. Was case referred to medic examiner?	Hospital:			Oth	000	Death (Check only o	ne)			
e Properties	ral d	tlon: To	1 Inpatient 2 Erroutpatient 3 DOA 4 Nursing Home 3 es							esidence 6 Other (Specify) Sescribe how injury occurred			
UIVISI		Certification;								Street and wn, State)	Number or Ru	ral Route Number,	
he Hospit	he Funer	edical	29a. Certifier 1 Certify (Check only one) 1 Medica	ying Physician: To the bes al Examiner: On the basis and manners	of examina	owledge, deat ation and/or in	th occurred at the tire	me, date and popinion, death	place, and due to the occurred at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)	
Tot	To ti comp	Σ	29b. Signature and title of certif	fier Man		00 0	29c. Licens	e number	,	29d. Date	signed (Monti	n, Day, Year)	
			Mary	& Selle	1 1	11/13	DX	787		08/	02/0	5	
			30. Name d addres o y rsc	on who completed cause of	death (Ite	m 23a) (Type,	Print)	218	5-1				
- 0k	Sta Registi		31. Date filed (Month, Day, Yea	32. Regination 1	rar's Sign	ature	Sugar.	~ 1 1 - 1	<i>J</i>				

			For Stata Registrar	State of Ma	aryland / Depa	artment of F			giene Reg. No. 0	05 2	26289
			Decedent's Name (First, Middle, Las	st)				2. Date of Dea	ıth		3. Time of Death
	Physici /Medic		John C.	Smi	the Tr			Month 7	25	2005	10:15 A M
	Examin		4a. Facility Name (If not institution, give		1		r Location of Deat		4c. Cou	inty of Death	1
*				Greene		Baltimo					
r	Funeral		5. Social Security Number 6. Security Number 1	ex 7. Ag S⊋M 2□ F	e (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	Year)	9. Birthpl Coun	ace (State or Foreign try)
-	Director		413-72-0335 Usual Residence of Decedent	n	70 113.			Oct. 1/	, 1946	Mary	Land
	show		10a. State 10b. County		10c. City, Town or Lo	ocation				10	0d. Inside City Limits
	Marined	tor	Maryland Carroll		Westmin	ster					1 Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	try?
	ath w	ral	753 Windsor Drive			21158				ed Stat	
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	ipecify Yes or No- to Rican, etc.)		Race - America Black, White, e	
36	i's aff	by F	1 ☐ Never Married 255 Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 ☐ I If Yes, Give Year or Dates:	1964-	1□ Yes 2⊠ No	Specify:		Spe	ecity: Whi	te
21215-0036	within 72 hours after death with the Maryland ane. Than "natural", or Itams 23a or 28a-f show the Marifical Exami at must be invitilled at	ted	15. Decedent's Ed	lucation	1968 16a, Dece	dent's Usual Occup	ation		16b. Kind o	f Business/Ind	lustry
215	thin 7 e.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	life	kind of work done DO NOT use retired	during most of wo. d)	rking			£.
N	ed wil	Con	12			& Supply				space	
Maryland	12 should be filed within 72 hours after death with the Maryla h and Mental Hygiens of 18 has a second to 18 marked other than "natural", or Itams 23a or 28a-1 show I sammarked other than "natural", or Itams 23a or 28a-1 show traumatic evant, the Maxical Exert and must be redified at	Be	17. Father's Name (First, Middle, Last)	a				me (First, Middle,		name)	
7	J Mer narke	To	John Calvin Smith 19a. Informant's Name/Relationship (7)		10h Maili			y Jane Si		2	0.11
Ma	d 2 si th an th an traur traur		Karen Smith / Wif		1	ng Address <i>(Street</i> Vindsor D					Code)
CD	s 1 and 2 should f Health and Men fam 27 is marke othar traumatic		20a. Method of Disposition		20b. Place of Dispo				•	on - City or To	wn, State
D D	Pages ent of nt: If I		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Resthaven		,		reder	ick. Ma	aryland
Baltimore,	permit. Pages 1 and Department of Health Important: If Itam 27 any injury or other tr once.		21. Signature of Foreral Service Licen			2. Name and Addre					
00	Deparming any ir		Valala		0,1	501 Catao	tin Mtn	Urre En			
			23a. Part I. Enter the disease, or corpushock, or heart failure. List only	nications that caused one cause on each li	the death. Do not en	er the mode of dyin	g, such as cardia	or respiratory ari	est,		Approximate Interval Between
2	nysician	5 IV	Immediate Cause (Final disease or condition	a Basil		ery th					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	1		0			
		40	Sequentially list conditions, if any, leading to immediate	b. Srau	a consequence of):	h					
	uted I Insit	Examiner	Cause (Disease or injury								
ó	The law requires that the death certificate be exacuted the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequence of):						
8760,	ate be nysicia ne bu	dical		. d							
39 3	ntifica ing pt	w T	IF FEMALE:								
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	,		1	Date of deliver Month	ry Day Year
0.	at the de by the a rtached f	Physician/M	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death 5 L	Other (specify) _					,
٣.	res that t igned by be detac		Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use c	ontribute to the	e cause of death?
Records,	puires n sign lld be	d by						1 □ Y	es 2 No	3 Proba	ably 4 Unknown
O CO	s baen s shoul	Completed						24a. Was a	an 24	b. Were autop	osy findings available appletion of cause of
Re	The lay te has age 2	ome						autop: perfor	med? 2 No	death?	pletion of cause of
		a	25. Was case referred to medical				26. Place of Dea	ath (Check only or		10103	242 110
of V	Physician: this certific ral director,	To B	examiner? 1 □ Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing H	lome 5 ☐ Resid	ence 6 🗆	Other (Specify)
_	fter ne		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o y Year) Injury	f 28c. Injur Wor	y at k?	28d. Describe h	ow injury oc	curred	
sio	Attanding ir death. actor: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
Division	or Al after of Dirac in by	Certification:	4 ☐ Homicide determined	building, et	ury · At home, farm, str c. (Specify)	eet, factory, office		28f. Location (S City or Tow		imber or Hural	Houte Number,
	To tha Hospital or Attandii within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu		29a. Certifier 1 Cartifying Ph	ysician: To the best	of my knowledge, deat	h occurred at the tin	ne, date and place	, and due to the o	ause(s) and	manner as sta	ated.
	n 24 t n 24 t na Fu sletely	edical	(Check only 2 ☐ Medical Examone)	ninar: On the basis of and manner st	examination and/or in	vestigation, in my o	pinion, death occu	irred at the time, d	late and place	ce, and due to	the cause(s)
	To the To the Comp	×	29b. Signature and title of pertifier	1 1		29c. Licens			,	ned (Month, L	
)	MA		chally 16	well		165	37		July	26,	2005
4	9x /.		- 1/ 1/	1 1 4-	eath (Item 23a) (Type,	Print) Freeze 5		Waxa 2	11.	1177 0	1 201 /
			31. Date filed (Month Day, Kear)		22 S. (ar's Signature	freeze 5	r. Dunte S	4001, Ba	It. more	My 2	1201
14	Sta	te ar	31. Date filed (Mojble 2 8 20	05	za M. A.	a. K .					

			- For Amend Items 2	State of Marylar 25 ,27,28a -f	nd/Depa er MF	artment of 1	Health and 25/05dhl	Mental Hyg	giene 100 20 0 5	26290
	Physici	an	1. Decedent's Name (First, Middle, Last) Charles			ith		2. Date of Dea Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	711		or Location of De	eath Dury of	4c. County of	
	LXumin	C1	THE JOHUS HOPE	KINS HOSPI	FAL	BALL	MORE	City		
	Funeral Director		042-01-1256	M 2DF	last birthday) 88 Yrs.	If Under 1 Year Months Days		in. (Month, Da)	h v, Year) 2 1916	Birthplace (State or Foreign Country)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation		• -		10d. Inside City Limits
	ith the Marylan or 28a-f show se notified at	tor	CT Hartfor	rđ	Plain	ville				1 ☐ Yes 2 ☐ No
	th the	Olrec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	ath wi	ral	19 Shuttlemeadow				06062			SA
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be notilied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	 Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 	1	Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 X No		(Specify Yes or No- erto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
5-0036	72 hou	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occu	pation	ending.	16b. Kind of Busin	ness/Industry
2121	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)	VOIKING		
121	filed withi Hygiene. other then ent, the M		12 17. Father's Name (First, Middle, Last)		Elec	trical M		ring Jame (First, Middle,	Manufa	acturing
land	d be f antal H red of	o Be	Alfred O. Smith				222.000	ine David		
Mary	2 should be t and Mental I is marked of sumatic eve	2	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Maili	ng Address (Stree	<u> </u>	Rural Route Numbe		ate, Zip Code)
_	1 and 2 Health a em 27 is		David Smith/son			Appaloo		Finksbu		21048
Baltimore ,	permit. Pages 1 an Department of Heal Importent: if Item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐R 4 ☐ Donation 5 ☐ Other (Specify)	BITIOVAL ITOITI SLALE		osition (Name of matory or other place) Ve Cremat	1	Date 2 / 2005	20c. Location - Ci Waterbur	
alti	permit. Departmitimporte any inju		21. Signature of Funeral Service License		2	2. Name and Addr	ess of Facility			
<u> </u>	89 = 28		Mal John					ome and C		
23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resistance. Physician (Medical disease or condition resulting in death) All 2 Washington Road or resistance. In the disease or condition as a Subdural hematoma								liac or respiratory an	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consec	quence of):			0//		/
		Jer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence ot):		TION APPROVED BY	TENTAL		
5	ate be executed thysiclen and the burial-transit	Examiner	that initiated events				W DB	CENCAL.		
760,	oe execten a		resulting in death) Last	Due to (or as a consec	quence of):	nda	MON ASPR			
700	physis	dical	d			CERTIFIC				
O. Box 6	law requires that the death certificate be executed as been signed by the attending physiclen and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of 0	al death 3[Ectopic pregnand Other (specify)	E.		23d. Date of Month	
نهر	that the ed by detac		Part II. Other significant conditions con	tributing to death but not re-	sulting in the u	inderlying cause g	iven in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
ds	quires n sign ald be	q p	myocardial	infarct	tion			1 □ Y	es 2 XNo 3	☐ Probably 4 ☐ Unknown
Records	9 4 9	Completed by	end stage	renal	dise	ase		24a. Was autop	sy pric	re autopsy findings available or to completion of cause of ath?
Vital	iicien: Th certificate rector, pag	e Co	25. Was case referred to medical				OC Diago of F		2 1	Yes 2 No
>		To B	examiner?	ospital: La Inpatient 2] ER/Outpatie	nt 3 DOA O	ther	g Home 5 Resid		(Specify)
J of	ng Ph ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				now injury occurred	
Siol	eath. or: Al	catle	2 XAccident investigation	July 15,200	5 11:3		Yes 2X No	Subjec	ct fell	
Division	To the Hospitel or Attending Phys within 24 hours efter death. To the Funerel Director: After this completely filled in by the funeral di	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	60	reet, factory, office rking lo		281. Location (S City or Tow	vn, State) 451	or Rural Route Number, Wac Drive
	he Hosp in 24 hou he Fune pletely fil	edical	29a. Certifier (Check only one) 1 ★ Certifying Phys 2 ★ Medical Examir	sician: To the best of my known. On the basis of examinand manner stated.	owledge, deat ation and/or in	th occurred at the to estigation, in my	time, date and pla opinion, death or	ace, and due to the occurred at the time, o	cause(s) and mann date and place, and	er as stated. If due to the cause(s)
		Σ	29b. Signature and title of certifier				ise number	1	29d. Date signed (i	
•	WIL			mo) mo		R	ES-00	0	July 2	5,2005
	8		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print)	Char	+ 2 11	2000	mD 21287
	Sta	te	Robert E Hoese 31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Molde	2100	Dalt	TIMORE	で タスク/
	Regist		JUL 2 7 2			breek				

5. Social Security Number

579-05-6588

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

Elizabeth Ruth Simpkins

1 □ M 2 🖸 F

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Yrs.

7. Age (In yrs. last birthday)

91

Certificate of Death

Months

4b. City, Town, or Location of Death

Leonardtown If Under 1 Year | If Under 24 Hrs.

Hours

Min.

Days

_	, 9.0						
	Reg.	No.	N	N	5	20	2 /
2.	Date of Death	-		~	100	3. 1	me

4c. County of Death

St. Mary's

2005

12:50 P M

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 XYes 2 No

Virginia

29

July

8. Date of Birth (Month, Day, Year)

8-17-1913

	73		Usual Residence o	f Decedent								
	land ow		10a. State	10b. County		10c. Cit	y, Town or Loca	tion				10d. Inside City Lin
	Mary a-f sh	tor	Maryland	St. M	arv's	Le	onardto	wn				1⊠Yes 2□
	th the	Director	10e. Street and Nu	mber				10f. Zip Code		10g.	Citizen of What C	ountry?
	th will		22680	Cedar L	ane Court			206	50		United	States
	r dea	Funeral	11. Marital Status		12. Was Decedent Armed Forces?)	S. 13. W	as Decedent of F es, specify Cub	Hispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Am Black, Wh	
920	urs afte al', or it	by	1 ☐ Never Marr 3 ☐Widowed	ied 2 Marrie 4 Divorced	d 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 [Yes 2√∑ No	Specify:		Specify: V	Vhite
21215-0036	within 72 hours after death with the Maryland ane. than "natural; or items 23a or 28a-f show ie Medical Examinat must be notified at	Completed	(Spec	15. Decedent's cify only highest	Education grade completed)		16a. Decede (Give ki	nt's Usual Occup nd of work done	pation during most of working id)	16b	Kind of Business	s/Industry
2121	D D F	omo	Elementary/Seco	ondary (0-12)	College (1-4or 9	5+)		Homemak			wn Home	
	be filed Ital Hygi Id other event,		17. Father's Name	(First, Middle, La	ast)				18. Mother's Name (F	First, Middle, Maid	len Sumame)	
Maryland	o d is b	To Be	Jesse	e Wood M	leeks				Mary El	len Brad	y	
lan,	2 should and Mer Is marke aumatic		19a. Informant's N	ame/Relationshi	р (Турө, Print)		19b. Mailing	Address (Street	and Number or Rural R	Route Number, Cit	y or Town, State,	Zip Code)
	1 and 2 Health em 27 I		Richard .	Johnson/	Son				raves Road,		.csville,	MD 20659
Baltimore,	S to E				B □Removal from State	C		ion (Name of tory or other pla 1n Ceme			Location - City of entwood,	Town, State Maryland
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Fi	11.60	1	M000		Name and Address	ess of Facility Brin ywood Road,			Home, P.A. 20650
			23a. Part1. Enter to shock, or hea	the disease, or c	omplications that caused nly one cause on each li	the deat	h. Do not enter	the mode of dyir	ng, such as cardiac or re	espiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final	a CC Due to (or as	PI	uence of):					Onset and Death
	Examiner and -transit	Examiner	Sequentially list or if any, leading to ir cause. Enter Unde Cause (Disease or that initiated event resulting in death)	erlying injury s	b. Due to or as	via	LF	imil	lation			
68760,	cate be executed physician and the burial-transit				dH	T	V					
P.O. Box 6	death certiff e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	Ideath 3 □E	ctopic pregnanc other (specify)	у		23d. Date of de Month	elivery Day Year
	res that fhe de signed by the a be detached f	by Ph	Part II. Other signi	ficant condition	s contributing to death b	out not res	ulting in the und	erlying cause giv	ven in Part I.			o the cause of death?
rd	w require been sig should b	ed	010							1 🗆 Yes	2 No 3 P	robably 4 Unkno
Il Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed by								24a. Was an autopsy performed	prior to death?	utopsy findings availa completion of cause

Vital Records, ELIZABETH RUTH SIMPKINS

Division of To the Hospital or Attending after death.

I Director: Af in by the fur

certificate has

this

After

Be Completed by

Certification; To

Medical

within 24 hours a To the Funeral I 3

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi

who completed cause of death (Item 23a) (Type, Print)

1 Inpatient

Date of Injury (Month, Day Year)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) -29-05

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one,

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

2 No 3 Probably 4 Unknown

CHARLOTTE HALL MD. 20622 37767 market place suite

MANOJ PANWALA M.D.

30. Name and address of perso

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 ANatural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year) AUG 0 3 2005

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

3□ DOA

1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: So the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

28c. Injury at Work?

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of	maryiar	-	tificate o	Health and If Death	•	giene Reg. Nø? 🗍 [15	26292
	Physicia		1. Decedent's Name	e (First, Middle, Las	t)					2. Date of De Month		Year	3. Time of Death
-	/Medica Examine	1	Mart 4a Facility Name (f)	in Antho		rnitsk _{ber)}	i		4b. City, Town, o	July or Location of Death	29 2	005	5:35 AM
Fı	uneral rector			a Manor		'. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Ye Months Day	Hage ar If Under 24 H	rstown	W:	ashin 9. Birthpl Count	gton ace (State or Foreign y I van i a
pue	}	- 1-	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Loc	eation				,	d. Inside City Limits
Meryl	23a or 28e-f show sast be notified at	ē,	Maryland	Washin	aton			lliamsp	ort				1 ☐ Yes 2 No
th the	or 28e	9	10e. Street and Nun		91011			10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
ath wi	and D	a	16106	6 Oak Tre					21795			USA	
020 urs efter de	raminer o		11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed	ed 2⊠ Married 4 □ Divorced	12. Was Deced Armed Ford 1 X Yes 2 If Yes, Give Year or Da	es? 2 □ No 194	43-	/as Decedent of Yes, specify C ☐ Yes 2 💢 N		(Specify Yes or No erto Rican, etc.)	- 14. Race Blac Specify	e - America k, White, e	
Maryland 21215-0020 d 2 should be filed within 72 hours efter death with the Merylend th end Mental Hygiene.	han "natur	Completed by	Elementary/Secon	15. Decedent's Edi fly only highest grad	ucetion de completed) College (1-		16a. Decede (Give k life. D	O NOT use ret	ne during most of w ired)	vorking	16b. Kind of Bu	isiness/Ind	ustry
d 212 filed with Hygiene.	= =	2	12 17. Father's Name (First, Middle, Last)				Machini		ame (First, Middle,	Truck Maiden Surnam		cturer
/lan uld be /ental	marked oth	0	Stanley	Shurnits	ki				France	es Tr	asko		
Z shore	<u>∞</u> <u>«</u>		19a. Informant's Na	me/Relationship (T	ype, Print)		19b. Mailing	Address (Stre	et and Number or i	Rural Route Numbe	er, City or Town,	Stete, Zip	Code)
1 end	tem 27 other ti	-	Ann Shurr	nitski-Wi	fe	20b. F	16106	Oak Tr ition (Name of atory or other p	ee Lane I	Williamsp Date	ort, Mary		
MOI Peges ent of	nt: # # ry or o		1 X Burial 2	Cremation 3 I	Removal from S	late							,Maryland
Baltimore, N permit. Peges 1 end Department of Health	important: any injury once.		21. Signature of Fur			01 6	රිජි	Der me ar	unereit H				
		+	23a. Part1. Enter the shock, or hear	e diseese, or comp	lications that car	used the deat							Approximate Interval Between
/Me	sician edical miner		Immediate Cause (I disease or conditior resulting in death)	Final	a	chro	nic	Ren	al Fo				Onset and Death
						Due to (o	r as a consequ	ience of):	v ć				
ecuted	physician end is the buriel-trensit		Sequentially list con	ditions,	b		r as a consequ		,	1		1	
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ox 68760, certificete be execut			resulting in death) L	ast	d	Due to (o	ras a consequ	ence of):				i	
. Box	od for u		Part II. Other signific	cant conditions co	ntributing to dea	th but not resi	ulting in the und	derivino cause i	given in Part I.	23b. Did t	obacco usa con	tributa to	tha causa of death?
ords, P.O	igned by the attending be deteched for use of the bedeched for use of the bedeched for use of the bedeched by by selection.	29			, , , , , , , , , , , , , , , , , , ,				g			3 ☐ Probe	
Division of Vital Records, or Attanding Physician: The law requires the fier death.	sete has been si page 2 should t										an autopsy med?	avai	e autopsy findings lable prior to pletion of cause eath?
Il Rec	page page									1111	65 24NU	1 🗆	Yes 2□ No
Vita iclen:	sertific rector,	3	25. Was case referre examiner?	/	Hospital:			10	Whor:	eath (Check only o			
Phys	erthis ca eral dire	1	1 □ Yes 2 □ 1 7. Manner-of Death	10	1 □ Inj	Injury	ER/Outpatient 28b. Time of	3∐ DOA 28c. In	urv at	Home 5 ☐ Resid	ence 6 Othe		
Vision of Vita Attending Physician: r death.	r: Affe		1 ☑Natural 2 ☐ Accident	5 Pending investigation	(Month,	Day Year)	Injury		ork? □Yes 2□No				
Divis	To the Functed Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Comp.		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place o building	f Injury - At ho , etc. <i>(Specif</i>)	ome, farm, stree /)	et, factory, offic	9	28f. Location (S City or Tow	itreet and Numbe n, State)	er or Rural	Route Number,
To the Hospital within 24 hours	Funer stely fil		29a. Certifier (Check only one)	Certifying Phys	ner: On the bas	is of examinat	wledge, death o ion and/or inve	occurred at the estigation, in my	time, date and place opinion, death occ	e, and due to the courred at the time, o	ause(s) and mar date and place, a	nner as sta ind due to t	ted. the cause(s)
o the	Nec		29b. Signature and t	itle of certifier	and manne	r Stated.			nse number		29d. Date signed	(Month, D	ay, Year)
F 51	- 0) =	m ping	pul			Do	106037	6	07/2	291	05
H 4+	-1	3	0. Name and addre	ss of person who co	ompleted cause	of death (Item	23e) (Type, P	rint) 11	16 08		~~ ·	MD	21740
	State Registrar		31. Date filed (Month	UL 29 201		istrar's Signa	ture	4.	+ + -	O	1		

			State of Maryland / Departm		lental Hygier	ne	
				cate of Death	Reg.	NOZ U U 5	26293
ব	Physicia	ın	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medic	al	CLARENCE W. SCOTT SR.		July 21		8:22 a M
	Examin	er		City, Town, or Location of Death		4c. County of Deat	
	Funeral	-	Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Takoma Par Jnder 1 Year If Under 24 Hrs.	8. Date of Birth	Montgom 9. Birt	hplace (State or Foreign
	Director		579-16-8923 1 ¹ M 2□ F 84 Yrs. Mor	nths Days Hours Min.	8. Date of Birth (Month, Day, Ye. Sept. 28,	1920 C	olorado
	2		Usual Residence of Decedent				
	shov	2	10a. State 10b. County 10c. City, Town or Location MD Prince Georges Capit	al Heights			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-f	ecto		of. Zip Code	100	Citizen of What Co	
ź	3a or	Funeral Director	507 Ashleaf Ave.	20743	Tog.	U.S.A.	unity?
1	ms 2	era		Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	rican Indian,
5	or Ite	F	1 Never Married 2 Married 1 Yes 2 ₹No		Rican, etc.)	Black, White	e, etc.
3	in in in in in in in in in in in in in i	d by	3 Widowed 4 Divorced Year or Dates:	'es 2₺ No <i>Specify:</i>		Specify: Bl	ack
5	"natu	Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind (Give kind to Political P	Usual Occupation of work done during most of work OT use retired)	ing 16b	. Kind of Business/	Industry
7	withing with the man	mo	Elementary/Secondary (0-12) College (1-4or 5+)	ıard		ecurity	
י ע כ	lal Hygiene international action with the maryland in Hygiene. d other than "natural", or tems 23a or 28a-f show event, If a Modical Exercit or must be notified at	a)	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
2	Hental Hed c ic ev	0	Charles Scott		Mary W	right	
ם א	should and Men s marke umatic	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	dress (Street and Number or Run	al Route Number, Cit	ty or Town, State, Z	Tip Code)
, Ma	and 2 ealth a n 27 is ier trau			Eastern Ave.C	apital H	gts,Md.	20743
υ.	of He		20a. Method of Disposition 1 St Burial 2 Cremation 3 Removal from State	y or other place)		. Location - City or	
	tant: If it		'4 □Donation 5 □Other (Specify) FORT Line	coln Cem July	26,05	Brentwo	od,MD
ספו	permit. Pages I am 2 should be thew which 72 hours after death with the waryan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examinet must be notified at once.			B Kennedy St.	unt Fune N.W.Wash	ral Hom	e 011
	1000		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition				Onset and Death
	/Medical Examiner		resulting in death) Due to use as a construence of):				
H		er	Sequentially list conditions. b. Due to (or as a consequence of)				
	nsit ed	nine	cause. Enter Underlying Cause (Disease or injury				
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00/0	cate be executed physician and the burial-transit	dicai	d				
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5	ine law requires triat the death cerrinities has been signed by the attending page 2 should be detached for use as	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 Other	er (specify)		No.	34,
Ŀ	ed by detac		Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
cords,	ulres Isign Id be	d by	Rad Farbres		1 ☐ Yes	2 No 3 Pr	obabiy 4 Unknown
2	been si should	ompleted	Danceho		24a. Was an	24b. Were au	topsy findings available
ב ו	stotan: The law certificate has b irector, page 2 s	mo			autopsy performed 1 ☐ Yes 2 🔀	prior to death?	completion of cause of
	rtifica ctor, p	BeC	25. Was case referred to medical examiner?	26. Place of Deat	(Check only one)	140	2010
5 2	rnysician: r this certific ral director,	To	Hospital:	☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence	6 □Other (Spec	cify)
	ing after	ou:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 1 ☐ Pending 28b. Time of Injury	Work?	28d. Describe how in	njury occurred	
2	tor: /	icat	2 Accident investigation 3 Suicide 6 Could not be		204		
2	after a	Certification:	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street City or Town, St		rai Houte Number,
	lo the hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 ☆Certifying Physician: To the best of my knowledge, death occu	urred at the time, date and place.	and due to the cause	e(s) and manner as	stated.
-	n 24 h	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.	gation, in my opinion, death occurr	ed at the time, date	and place, and due	to the cause(s)
1	withi To tl	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	
				1245660		7-21-0	J
-1	3)		30. Name and address of person who completed cause of seath (Item 23a) (Type, Print)	Cev (N.	124	Ben.	em D 2278
	-64		31. Date filed (Month, Day, Year) 32. Registrar's Signature	T 0 0	(- (
	Sta Registr		JUL 2 7 2005 Refer & Small				
				<u></u>			

			1 - For State Registrar	State of M	aryland		artmen tificate			and M		iene	05	262	94
	Physicia /Medic		1. Decedent's Name (First, Middle Angela M.	Serrano							2. Date of Dea Month July	Day 26	2005	3. Time of 8:55	
	Examin		4a. Facility Name (If not institution,	give street and number	r)		4b. City,	Town, or	Location of	of Death		4c. Cou	nty of Death		
			Hospice of the						nicum				Arun	del	
	Funeral Director		5. Social Security Number 054-18-0088 Usual Residence of Decedent	6. Sex 7. A 1 □ M 2 ☒ F	ge (In yrs. Ia 89	st birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day Mar. 29	,1916	9. Birth Cou New	place (State of ntry) York	r Foreign
	ow ow		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside Ci	ty Limits
	a-f sh	tor	MD Anne A	runde1		Croft	on							1 XYes	2 🗌 No
	or 28	Oire	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Cou	ntry?	
	ath w	rai	917 Truro Lane					211				US.			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 X Widowed 4 Divorced	12. Was Deceden Armed Forces at 1 Tyes 2 Tyes, Give Year or Dates	?] No	1	Was Deced fYes, spec 1 ☐ Yes 2		spanic Origon, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White, Icify: Whi	etc.	
2-0	72 ho	Completed	15. Decedent' (Specify only highest			16a. Dece	dent's Usua	l Occupa	ition	t of worki	ina	16b. Kind o	f Business/Ir		
121	Man Man	mpie	Elementary/Secondary (0-12)	College (1-40)	5+)		kind of wor DO NOT us)	o work	,,,	ъ.			
5	Hygie Hygie ther t nt, In		12 17. Father's Name (First, Middle, L	ast)		Da	ta En	try	18 Mothe	r's Name	(First, Middle, i		king		
Maryland	ould be I Mental I harked o	To Be	Charles Ingeni	to					Anna	a Mai	ria Avit	abile			
Mar	d 2 sh th and 7 la m traum	1	19a. Informant's Name/Relationsh John J. Serrano		- 3	19b. Mailir 917 T				_	al Route Number			o Code)	
	Heali Heali tem 2		20a. Method of Disposition	7 3011	20b. Pla	Ge of Dispo				************	on, MD.	211 20c. Locatio	n - City or T	own, State	
E O	Pages ent of nt: If it ry or o		1 → Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		9					77/20	9/2005 D				
Baltimore,	permit. I Departm Importar any injur		21. Signature of Funeral Service L		Дакс	22	Name and	d Addres	s of Facilit	y Bea	all Fune Bowie,	ral H			
8760,	Physician /Medical Examiner and physician stree private the private transit	ai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last	a	s a conseque s a conseque s a conseque	en ve if): ence of):	Can		g, such as	cardiac	or respiratory arr	est,		Approximation interval Bath Onset and I	ween
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	Se ugu	by	Part II. Other significant condition	ns contributing to death	but not result	ting in the u	nderlying ca	ause give	n in Part I.					he cause of d pably 4 ⊡U	
Vital Records,	The law ate has b	Completed								-	24a. Was a autops perform	y	b. Were auto prior to co death? 1 🗌 Yes	opsy findings ampletion of ca	available ause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death	(Check only on	e)			
of	ding Phys h. After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of In (Month, D	ient 2 E jury 2 ay Year)	R/Outpatien 28b. Time of Injury		Bc. Injury Work	4 LI NU		me 5 ☐ Reside 28d. De <i>s</i> cribe ho		- ' '	y) Hosi	pice
Division	afte Dir	Certification;	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of I	njury - At hometc. (Specify)	ne, farm, str	eet, factory	, office		1	28f. Location (St City or Town		mber or Run	al Route Num	ber,
	ne Hospital n 24 hours a he Funeral I	edicai (29a. Certifier 1 Certifying (Check only one)	Physician: To the bes examiner: On the basis and manner s	of examination	ledge, death on and/or in-	occurred a vestigation,	at the tim in my op	e, date and inion, deal	d place, a	and due to the co	ause(s) and ate and plac	manner as s	tated. o the cause(s)
	To the I within 2 To the I complet	Σ	29b. Signature and title of centiler				29c	License	number		2	9d. Date sig	ned (Month,	Day, Year)	
				× /	Cen			03	160	2		7/2	4/5		
R	- B)		30. Name and ad ress of perso						1	1100	D				
			George B. Cavan 31. Date filed (Month, Day, Year)		4201 M trar's Signatu		11vil	le R	d. #	102	Bowie,	MD.	20/16		
	Sta Registr		JUL 2 7 20		, J		Es.								

Document Document				1 - For State Registrar	State of Maryla		artment of F		_	giene Reg. No2 () (15 26295
As Fashly Area of the Assessment Fashly Assessment of Teachers of Design Control Contr	H					S	Shober, Sr.			Day	Year
Secretary Control Co				4a. Facility Name (If not institution	, give street and number)		4b. City, Town, o	or Location of Death			
Second Security Number Sold Price And Pric		=xa		SACRED HEAD	ET HOSPITAL		Cun	ABERLAN	au	AL	LEGANY
The contract and Number Contract and Num				213-24-5483	1ÑM 2□F				8. Date of Bir (Month, Da 06/21/19	th ly, Year) 929	9. Birthplace (State or Foreign Country) Iaryland
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CIGILE 1611 A NEW AAAL		nus		30. Name and address of person	who completed cause of death (Its	em 23a) (Type	Print) Walsh	Road	Cumb	erland	mD 21506
Registrar JUL 2 7 2005 Meses M. Society				31. Date filed (Month, Day, Year)			Soule				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 19, July 2005 0400 Reynard Donnell Surles /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1√2 M 2 □ F Months 34 578-08-4377 Director Washingto Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Capitol Heights P.G. MD 1 Yes 2 □ No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20743 1542 Nova Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2▼No fYes Give 1 Yes 2 XNo Specify: Black Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private 2 years Hospitality Services 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Brenda Grissom David Arthur Surles, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4477 B Street, S.E. #202 Washington, D.C. 20019 19a. Informant's Name/Relationship (Type, Print) Brenda J. Grissom - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 7/23/05 Clinton, Marylan Resurrection Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Signatury of Funeral Service Licensee P.O. Box 416; Suitland, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician 2 days Hyporkalemia
Due to (or as a consequence of) disease or condition resulting in death) /Medical Examiner Endstage Renal Disease 18 mos Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. by page 2 should be 2 No Hypertension 1 Tes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an HIV autopsy Myocardial Ischemia 2 X No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Att completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WD. 07/22/2005 D0045121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road; Silver Spring, MD 20910 Brain F. Reagan, M.D. 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 7 2005 Registra

			101	epartment of Health and Menta Certificate of Death	Al Hygiene	26297
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	/Medi Examir		4a. Facility Name (If not institution, give street and number) Wicomico Nursing Home	4b. City, Town, or Location of Death Salisbury	4c. County of Dea	ıth
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birtho	Months Days Hours Min (Mo	te of Birth onth, Day, Year) 9. Bi	thplace (State or Foreign ountry)
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Salis	r Location		10d. Inside City Limits 1 Yes 2 □ No
	with the P or 28e- be notifi	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?
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0036	ours after irei', or ite	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	etc.) Black, Whi	B/ACK
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. od other then "naturel", or items 23a or 28e-1 show event, the Medical Example in unit be notified at	Completed	(Specify only highest grade completed) (G	seedent's Usual Occupation live kind of work done during most of working live kind of work and the during most of working LPN	West Park	Vindustry Hasaital
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Man	12 s h ar 7 ls treu	·	19a. Informant's Name/Relationship (Type, Print) 19b. M	Mailing Address (Street and Number or Rural Route	Walter and the second	Zip Code)
ore,	of H		20a. Method of Disposition 20b. Place of Disposition 1 KBurial 2 Cremation 3 Removal from State	isposition (Name of Crematory or other place)	20c. Location - City of	Town, State
Baltimore,	1 5 5 5		*4 □ Donation 5 □ Other (Specify) 21. Signature of Furteral Service Licensee	bley Church Cenety 7/30/0 22 Name and Address of Fallity	15 White Have	n,MO
B B	Depa impo any ir any ir		23a. Part1. Enter the disease, or complications that caused the death. Do not	917 W. Isabella St. SA	Hisbury, MO =	2/80 / Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	To THRIVE	ratory arresty	Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	1111111111	loni	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	17.17 [7.17 & C.1.1]	0,0	
8760,	cate be executed obysician and the burial-transit	dicai Exa	resulting in death) Last Due to (or as a consequence of):			
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Vita	Physicien: The lathis certificate hat all director, page 3	o Be C	25. Was case relerred to medical examiner?	26. Place of Death (Chec	ck only one)	
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	To the Hospitei or within 24 hours after To the Funerel Discompletely filled in	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, described in the desired of the desired in	eath occurred at the time, date and place, and due if investigation, in my opinion, death occurred at the	e to the cause(s) and manner a ne time, date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Ty		1/26/0	5
	Sta	te.	Mahesha Thimmarayappa M.D. 6 31. Date liled (Month, Day, Year) 32. Registrar's Signature	14 Easternshore Dr	Salisbury M	D 21804
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			For State Registrar	State of M	arylan	•	artment of <i>tificate of</i>		d Mental Hy	giene	005	26298
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	/Medic Examir		4a. Facility Name (If not institution,)		4b. City, Town,	or Location of De		4c. Co	unty of Death	1 2047 11
	Funeral Director		10572 Mt. Savage 5. Social Security Number 220-38-2384	. Sex 7. Ag	ge (In yrs. I	la <i>st birthday)</i> Yrs.	If Under 1 Yea Months Days	r If Under 24 F	Hrs. 8. Date of Bi Month, D 07/11/1		9. Birth	place (State or Foreign http:/ y Land
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36	after or Ite	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces	?)- '		Hispanic Origin? ban, Mexican, Pt	(Specify Yes or N uerto Rican, etc.)	0- 14.	Race - Americ Black, White, ecify: Whit	etc.
Maryland 21215-0036	"natur	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or		16a. Deced	DO NOT use retir	e during most of sed)	working		of Business/In	
d 2	filed within I Hygiene. other then	e Co	11 17. Father's Name (First, Middle, La	st)			Conductor		Name (First, Middle	1	ailroad mame)	
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Mar	nd 2 sh lith and 27 le m r treum		19a. Informant's Name/Relationship Eleeta E. Shirey / w			1.			W., Cumberl	-		·
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 le marke any injury or other treumatic <u>once</u> .		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3	☐Removal from State	0	lace of Dispo emetery, cren	sition (Name of natory or other pl	ace)	Date	20c. Locati	ion - City or To	own, State
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	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the I	edical C	29a. Certifier (Check only one) 1 X Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examinat	wledge, death tion and/or inv	occurred at the restigation, in my	time, date and pla opinion, death or	ace, and due to the ccurred at the time,	cause(s) and date and pla	f manner as si ce, and due to	tated. the cause(s)
	1	Me	29b. Signature and title of certifier	TW	/			nse number			gned (Month,	Day, Year)
8		i	30. Name and address of person when the same and address of the same address of the same and address of the same and address of the same address of th				Print)	00023371		outh 2	25, 2005	
	n Rd			an, M.D., 62				nd, Maryla	and 21502			
	Sta Regista		31. Date filed (Month, Day, Year) JUL 25	2005	المحدد .	Turk A	the Ball of the					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 16, Day 2005 Year Physician 7:02 Thomas Catherine /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 3114 Gracefield Road Apt. #508 Spring
If Under 24 Hrs. Montgomery

9. Birthplace (State or Foreign Silver 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1907 Salisbury, MD 7. Age (In yrs. last birthday) 5. Social Security Number 155-14-4462 **Funeral** 1□ M 21 F Days Hours 97 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County If item 27 is marked other than "natural", or items 23s or 28s-f show or other treumstic event, it a Medical Examinar mast be notified at Y Yes 2 □ No Maryland Maryland Silver Spring Montgomery Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 3114 Gracefield/Road Apt. #508 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government f Health and Mental Hygi Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Catherine Richardson L. Wilson Pinkett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin E. Pinkett - Nephew 8103 Cedargate Place Glenn Dale, MD 20769 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages
Depertment of h
important: If ite
sny injury or of 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery July 20, 2005 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4001 Benning Road, NE Washington, DC 20019 12/m 23a. Part 1 anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Cardiac Arrhythmia **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physicien: The law requires that the death certificete be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Day Month been signed by the atter-should be detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Munknown Neoplasma Rectal, Arterial Fibrilation Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Congestive Heart Failure autopsy performed 1 Yes 2 No Director: After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🔀 No 4 ☐ Nursing Home 5 E Residence 6 ☐ Other (Specify) 1 🗀 Inpatient 2 ER/Outpatient Medical Certification; To 3 DOA 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 🗋 Homicide within 24 hours a To the Funerel I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifi 0 D24035 July 19, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road Silver Spring, MD 20904 Eugenio Mhchado, M.D. 31. Date filed (Month, Day, Year) State 2 8 2005 Registrar

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of		nd Mental F		2005	26300
	S ! -:-:-:		1. Decedent's Name (First, Middle, La	st)				2. Date of Month	D	ay Year	3. Time of Death
	Physici /Medic		Natalie A. Thom	as				July	24,	2005	10:40 A M
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town,		Death	4	c. County of Deal	
			Holy Cross Hosp			Silver		Um I -		Montgom	
	Funeral		5. Social Security Number 6. S 579-84-6082	ex 7. Ag ☐ M 2[X] F	e (In yrs. last birthda) 45 Yrs.	Months Days		Min (Month.	Birth Day, Yea 10,	1960 Sou	hplace (State or Foreign buntry) th Dakota
	Director		Usual Residence of Decedent					June	10,	1700 300	en bakoea
	yland yland		10a. State 10b. County	_	10c. City, Town or I	ocation					10d. Inside City Limits
	a-fsl	ctor	D.C. N/A		Washing	gton					Y Yes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23e or 28e-f show other traumatic event, the Medical Examinating the routilized at	by Funeral Director	10e. Street and Number 503 Madison Stre	et, N.W.		10f. Zip Code 20011			1	nited St	•
	dear	ner	11. Marital Status	12. Was Decedent Armed Forces? 1 Yes 24	Ever in U.S. 13	. Was Decedent of If Yes, specify Cui	Hispanic Origin ban, Mexican, I	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit	
36	or It	y Fu	1X Never Married 2 Married	If Yes, Give	No	1 ☐ Yes 2X No					egro
ő	hours tural	d be	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16a Dec	edent's Usual Occu	unation		16h	Kind of Business	Industry
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21215-0036	d with piene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5)+)	N/A			N	/A	
פָּ	e filec otha vant,	BeC	17. Father's Name (First, Middle, Last,					s Name (First, Mic			
/lar	Mente Mente arked	ToE	George Lee Thoma	S			Barba	ara Ann '	nomp	son	
Maryland	and 2 should be filed within " salth and Mental Hygiene. n 27 is marked othar than " iar fraumatic evant, tha Mer.		19a. Informant's Name/Relationship (ling Address (Stree Madison					
e, N	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or othar tra ance.		Barbara Ann Thom 20a. Method of Disposition	as / moti	20b. Place of Disp		PLIECE	Date		Location - City or	
Baltimore,	Pages nent of h		1 Burial 2 ☐ Cremation 3 ☐		cemetery, cr	ematory or other pl					
Iŧi	Departmen Important: Pa any injury		 4 □Donation 5 □Other (Special 21. Signature of Funeral Service Lie 			oln Cemet		7/30/05			Maryland
Ba	permit. Departr Imports any inju		Fraun G.	Elleberre	1	7400 Geoi					
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	/Medical		disease or condition resulting in death)		a consequence of):						MOTIBILE
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	and and I-trans	хаш	that initiated events resulting in death) Last		Encephlo a consequence of):	pathy					years
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687	ficate phys s the	edic		_ d							
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	death e atte id for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		☐ Ectopic pregnan☐ Other (specify)	icy		_	Month	Day Year
P.0	that the de led by the a detached f	hys	9 ☐ Unknown	9□ Unknown							
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Records,	w require been si should I	Completed							-		
ec	has b	nple						24a. V	utonsv	24b. Were as prior to death?	utopsy findings available completion of cause of
E H	T ate									No 1 ☐ Yes	2 □ No
Vite	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: .	- 7-5)th an	f Death (Check or		- 57-11	
of Vital	S 0	7	1 Yes 2 No 27. Manner of Death	28a Date of Inju	rv 28b. Time	BILL 3 DOA	4 🗆 14013	ing Home 5 F		6 ∐Other (Spe jury occurred	city)
on	Attanding Ir death. actor: After by the funer	tlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Year) Injury		fork? □Yes 2□No				
Division	Attandi r death. actor: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, farm, s c. (Specify)	street, factory, office	e		n (Street Town, Sta		ural Route Number,
ā	s afte	Cert	4 Homicide	Building, et	c. (Specily)			Only of	101411, 016	110/	
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	Medical (nysicien: To the best miner: On the basis o and manner st	f examination and/or						
	ithin 2 o the	Mec	29b Signature and little of certifier			29c. Licer	nse number		29d. D	Date signed (Mon	th, Day, Year)
	6 <u>1</u> £ <u>1</u>			awn 3	*	De	2092	7	7	- 26-	-05
			30. Name and address of person who	completed cause of o	death (Item 23a) (Tyn	e, Print)	- 10	1	<u></u>		
	5		AHMED NAW	+2 mo	POBOX	83819	Laa	iithers	bu	rg m	(n, Day, Year)
	4 Sta		21 Date filed (Month Day Vear)	2005 32. G gistr	rar's Signature	marke				0	
	Regist	rar	30L & 0	ZUUJ JAN	100 10 1						

			For State Registrar	State of Maryl	•	artment of H			giene	26301
			1. Decedent's Name (First, Middle, La	it)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physicia /Medic		ROBERT	CHAPMAN	T	JRNER			26 2005	11:04 A ^M
	Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County of Dea	
_			FRIENDS NURSI 5. Social Security Number 6. S		yrs. last birthday)	SANDY If Under 1 Year	SPRING If Under 24 Hrs.	8. Date of Birth	MONTGON	
	Funeral Director		1	M2 M 2□F 92	yrs. iast oittiday) Yrs.	Months Days	Hours Min.	(Month, Day		thplace (State or Foreign buntry) W York
			Usual Residence of Decedent	92				July 2	2,1913 Ne	W TOLK
	irylan show		10a. State 10b. County		. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 📉 No
	8e-fs	ecto	Md. Montgome	ery	San	dy Spring	Ī			
	h with ti 23a or 2 st be n	al Dir	10e. Street and Number 17211 Quaker Lai	ne ne		10f. Zip Code	20860		10g. Citizen of What Co United Sta	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If tiern 27 Is marked other than "natural; or Itams 23a or 28e-f show any injury or other traumatic event, the Medical Exercitive must be notified alone.	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	e, etc.
5	tural		15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation	1	16b. Kind of Business	hite /Industry
2	nin 72 '' '' ni Medik	Completed	(Specify only highest gra		(Give	kind of work done of DO NOT use retired	durina most of workii	ng		
7	giene giene er the	E OC	12	66	Cera	mic Artis	st		Ceramic A	rts
2	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last, Henry Chandlee	กำหาค ห			18. Mother's Name			
<u>y</u>	Ment Marke Marke Marke	ပ					Charlott			
200	12 sh h and 7 Is rr traum		19a. Informant's Name/Relationship (r, City or Town, State, . .ng , Md . 20	
ב ע	1 and Healti em 2	-	Sue Thomas Turne: 20a. Method of Disposition		b. Place of Dispo	sition (Name of	. D	ate	20c. Location - City or	
	ages int of t: If it		1 ☐ Burial 2 🗷 Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, crei	natory or other plac	(e)	1		
	artme ortani injury	/	21. Signature of Funeral Service Licer				atory 7/27 ss of Facility	A STATE OF THE PARTY OF THE PAR	Alexandria	, va.
0	permit Depart Import any in		movie N.	Barker			ss of Facility Barber F			0882
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the cone cause on each line.			ng, such as cardiac	r respiratory arr	est,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cor		rarrarc				Months
	Examiner		Sequentially list conditions	b						
	р і	iner	Sequentially list conditions, if any, leading to immediate cause. Entire funderlying Cause (Disease or injury	Due to (or as a cor	nsequence of):					
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0	physicate s the	dicai		. d						
. DOX .	The law requires that the death certificate be executed are has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pro	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
	d by t	Phy	Part II. Other significant conditions of	ontributing to death but no	t reculting in the u	ndorhijna causa au	on in Part I	23e Did to	bacco use contribute to	the cause of death?
, D D	quires that n signed I uld be det	by	Part II. Other significant conditions of	ontributing to death but hot	riesulting in the u	nderlying cause giv	en ar Faiti.			robably 4 AUnknown
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	The ate h	E C						perfor	med? death?	2 □ No
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5	hysio this call dire	ို	1 ☐ Yes 2 🔀 No		2 ER/Outpatier		4 K I vursing non		ence 6 Other (Spe	cify)
5	ding F	ilon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	Wor		28d. Describe no	ow injury occurred	
	Attender death ector:	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, str			28f. Location (Si City or Town	treet and Number or R	ural Route Number,
5	tel or rs afte el Dir ed in	Cert	T I I I I I I I I I I I I I I I I I I I	building, etc. (3)	ocily)		<u> </u>	Only or Your	n, State)	
	To the Hospitel or Attending Physician: The I within 24 Hours after death. To the Funerel Director: After this cardificate he completely filled in by the funeral director, page	edical	29a. Certifier 1 Check only one) 1 Medical Exam	ysicien: To the best of my niner: On the basis of exar and manner stated.	knowledge, death mination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the coded at the time, d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. Licens		,	29d. Date signed (Mont	
			D'M. Ham	Man M		DOC	02312	4 9/	27/200	55
	10		30. Name and address of person who			Print)				
	10		Dennis M. Hannon				ing Road,	Olney,	Md. 20832	
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Registrar's S	ignature	parke				

			1 - For State Registrar	State of Ma	-	epartment of Certificate				giene	0.5	263	02
	Physici /Medi	al	Decedent's Name (First, Middle, Last, Aa. Facility Name (If not institution, give	MARY E	LIZABE	TH TAYL			2. Date of Dea Month	Day	Year 005	3. Time of 5:59	
	Examir Funeral	ier	CARROLL HOSPIT 5. Social Security Number 6. Securi	TAL CENTE	ER (In yrs. last birth:	WEST		ER	B. Date of Birt	CA	ARROL 9. Birth		or Foreign
	Director		214-16-0240 Usual Residence of Decedent 10a. State 10b. County	M 2⊠F	87 Yr	S.	Days Hours	Min.	10/12	/1917	7 MAR	YLAND 10d. Inside Ci	
	the Mary r 28a-f sho notified	Director	MD CARROLI 10e. Street and Number	1		INSTER	ode			10g. Citizen	of What Cou	1 🗌 Yes	•
	ath with		629 SPRING MILI				21157			USF	<i>A</i>		
9036	be filed within 72 hours after death with the Maryland ital Hygiene. bd other than "natural", or Itams 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates:		13. Was Deceder If Yes, specify 1 ☐ Yes 🏖			ify Yes or No- can, etc.)		Race - Amer Black, White Boify: WH		
Maryland 21215-0036	within 72 ha iene. • than "natu he Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(6	ecedent's Usual C Bive kind of work of te. DO NOT use i	done durina mo				f Business/li	•	
nd 2	ba filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last)				18. Moti	her's Name (First, Middle,	Maiden Sun	name)		
ıryla	2 should be and Mental Is marked aumatic ev	^C	'I'H0 19a. Informant's Name/Relationship (Ty	OMAS HERI		NKERT lailing Address (S			RACE E			'n Codel	
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altim	H 문문음 .		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligense 	D1	EER PAF	22. Name and	TERY	7/25/		MALL			
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of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	atlon: To	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Tim	e of 28c.	Injury at Work?	280	5 Reside			fy)	
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	e Hosp 24 hou e Funei letely fil	edical	29a. Certifier 1 Pertifying Physical (Check only one) 2 Medical Exemination	ician: To the best of ner: On the basis of e and manner state	my knowledge, d xamination and/o d.	eath occurred at t r investigation, in	he time, date a my opinion, de	and place, and path occurred	d due to the ca at the time, d	ause(s) and ate and plac	manner as s e, and due t	stated. o the cause(s)	
Y	To th Withir To th comp	Me	29b. Signature and title of certifier	MO	-	29c. Li	cense number	076	2	9d. Date sig	ned (Month,	Day, Year)	0
	MA		29a. Certifier (Check only) 2 □ Medical Exemin 29b. Signature and title of certifier 30. Name and address of person who co CHACLO 31. Date filed (Month, Day, Year)	mpleted cause of dea	th (Item 23a) (Ty	pe, Print)	11	201		JAIU	2	2107	
	° Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	toned is Signature	Kenve	, ~	MIN	ns:12			137	
	Registr		.1111 2 2 2	nns Block	w K	South?							

			For State	State of Maryla		artment of H			_	A	26202
			Registrar 1. Decedent's Name (First, Middle, Las	7)	Ce	runcate or L	Jealli	2. Date of De	Reg. No.	005	26303
	Physici	an	Joseph	Thomas	Tat	1200		Month	Day		
	/Medic		4a. Fecility Name (If not institution, give		Tat	4b. City, Town, or	Location of De	July	21 _{4c}	2005 County of Death	10:00 P.M
	Examin	er		· ·						1ontgome	
	Funeral		Bel Pre Health & 5. Social Security Number 6. Se	X 7. Age (In yr	r s. last birthday)	Silver If Under 1 Year	If Under 24 F				place (State or Foreign ntry)
	Director		578-60-5951	³ M 2□F 58	Yrs.	Months Days	Hours M	in. (Month, Da 4/20/4	y, Year) .7		ington, D.C.
	D >		Usual Residence of Decedent 10a, State 10b, County	100 (City, Town or Lo						
	aryla ehov	<u>_</u>		100.	,,						10d. Inside City Limits 1X Yes 2 ☐ No
	he M	Director	D.C. 10e, Street and Number		Washing				10 000		
	a or	ă	5909 Clay St., N	.E. # 305		10f, Zip Code	200	10	10g. Citiz	zen of What Cou	ntry?
	leath	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13	Was Decedent of Hi			. 1	14. Race - Ameri	can Indian
(0	r iter	Fu	1 ☐ Never Married 2 ☑ Married	Armed Forces?			n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		Black, White,	
93	ral', o	Ď	3 Widowed 4 Divorced	1 ☑Yes 2 ☐ No If Yes, Give 1 66— Year or Dates: 66—	68	1 ☐ Yes 2 🔀 No	Specify:			Specify.	erican
5-0	within 72 hours after death with the Maryland ene. than "natural", or iteme 23s or 28a-f ehow ha Medical Evarriner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occupa	luring most of v	vorkina	16b. Kir	nd of Business/Ir	ndustry
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5	be filed within 72 hours after death with the Marylan ital Hygiene. od other then "neturel", or Iteme 23a or 28a-1 ehow event, the Medical Evandrer must be notified at		17. Father's Name (First, Middle, Last)	2 years	Po	ostal Cari		lame (First, Middle,		Post Of	rice
and	d be f	Be C	Mark T. Tatum					lhelmina		•	
<u> </u>	2 should be and Mental le marked or reumatic ever	ဥ	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailir	ng Address (Street a		Rural Route Numbe			o Code)
Baltimore, Maryland 21215-0036	77 11 11 11 11		Barbara J. Tatum/W		5909	Clay St.	,N.E.,#	305, Wash	ingt	on, D.C	20019
Je,	permit. Pages 1 and Department of Heali Importent: If Item 2 any injury or other ance.		20a. Method of Disposition	I .	Place of Dispo	sition (Name of natory or other place	9)	Date	20c. Loc	cation - City or T	own, State
Ĕ	Page nent ent: if		1 ☑ Burial 2 ☐ Cremation 3 ☐ I 14 ☐ Donation 5 ☐ Other (Specify)			Nat'l. Co		/05	T	riangle	, Va.
alt	permit. Departr Importe any inju		21. Signature of Funeral Service Licens	See	25	Name and Addres	s of Facility	Sons_Co.	. Tnc		
_	80 = 5 8		any W	· Simo	4	925 Burro	ughs Av	e.,N.E.,W	ashi	ngton,D	.C. 20019
			23a. Part 1. Enter the dispase, or comp shock, or heart failure. List only of	lications that caused the de ne cause on each line.	ath. Do not ent	er the mode of dying	, such as card	iac or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Multiple Co	erebrova	ascular A	ccident	.s]	Onset and Death Months
	/Medical Examiner		resulting in death)	Due to (or as e conse							
Н		-	Sequentially list conditions,	b. <u>Diabetes Me</u>	ellitus						
	nslt	in	Sequentially list conditions, if any, leading to furnishing cause. Enter Underlying Cause (Disease or injury	. Hypertensio							
Ć,	execunance and and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conse						-	
8760,	The law requires that the death certificate be executed to has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit	dicai		d							
9	ng ph	0	IF FEMALE:								
Вох	eath certific ettending p I for use as	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	ital death 3 [Ectopic pregnancy			2	3d. Date of delive Month	ery Day Year
0	the e	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify)				MOHU	Day 18a
۵.	that the death hed by the etter detached for u	by Physician/M	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause give	n in Part I	23e. Did to	bacco us	se contribute to t	he cause of death?
Vital Records,	signed d be del	d by		•	3	,					pably 4 ∐Unknown
cor	w requir	ete						24a. Was	20	24h More auto	ancy findings available
Re	he lav	Completed						- autop perfor	sy med?	death?	ppsy findings available mpletion of cause of
a			25. Was case referred to medical				Of Diagonal F	1 ☐ Yes Peath (Check only o		1 🗆 Yes	2 No
	ysician: The is certificate hadirector, page	To Be	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe	r .	Home 5 Resid		□Other (Specif	(4)
Division of	를 를 풀	i.i.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		at	28d. Describe h			<i>y</i> /
joi	andin aath. or: Af	atio	1 ANatural 5 Pending 2 Accident investigation	(main, buy rour)	quiy		es 2□No				
Νį	or Attending after death. Director: After in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (S City or Tow	itreet and n. State)	Number or Rura	al Route Number,
	urs af										
	To the Hospitel or Attent within 24 hours after deati To the Funerel Director: completely filled in by the	Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exem	sicien: To the best of my ki ner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the tim vestigation, in my op	e, date and pla inion, death oc	ce, and due to the c curred at the time, o	ause(s) a date and	and manner as s place, and due to	tated. the cause(s)
-	o the	Me	29b. Signature and title of certifier	and marmer stated.	$\overline{}$	29c. License	number		29d. Date	signed (Month,	Day, Year)
	⊢ s ⊢ ō		1 Sun Dal-	200	()	D/	487	1	_	1.22.	*
1/2	, 5		30. Name and address of person oc	ompleted cause of death (Ite	em 23a) (Type,		, _ ,				
V			Suresh C. Gupta	, M.D. 3503 I	Perry St	., Mt. Ra	ainier,	Md. 2071	2		
	Sta	-	31. Date filed (Month, Day, Year) JUL 2 7 2005	🛍 Registrar's Sign	pature dos	Le .	-				
	Registr	el 💮	JUL " 1 TOO								

			For		aryland / De	partment of	Health a	and Mental Hy	/giene	
			1 - State Registrar		<i>C</i>	ertificate o	t Death		Reg. 16. 0 ()	
	Physici	an	1. Decedent's Name (First, Middle, Las	•				2. Date of Do	Dav	3. Time of Death
, I	/Medi		BASIL TULLY			45 6% 7	16	AUGUS		05 6:35a M
4	Examir	ier	4a. Fecility Name (If not institution, give		Pohah	4b. City, Town	, or Location of tertow		4c. County of Kent	
			Chestertown Nu 5, Social Security Number 6, Se		e (In yrs. last birthda				rth	9. Birthplace (State or Foreign
	Funeral Director			C C	87 Yrs.	Months Day		Min. Sept	1 1917	New Jersey
	land w		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary -1 sh	ţ	MD Kent		Cheste	ertown				1∱2Yes 2□No
	rough	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
	7 with	DE	213 N. Queen S	t.		2162	20		U.S.A.	
	death	ner	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 1	3. Was Decedent of	Hispanic Orig	in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race	- American Indian, c, White, etc.
9	after or ite	by Funeral Director	1 Never Married 2 Married	1 to Yes 2 □ N If Yes, Give	10	1 ☐ Yes 2 N		r don't rhoun, olon,	Specify:	
8	urat',	d b	3 Nidowed 4 Divorced	Year or Dates:	MANTT					
5	within 72 hours after death with the Maryland ene. than "naturat", or items 23s or 28s-f show he Medical Exemirer must be notified at	Completed	15. Decedent's Ed (Specify only highest grad		16a. De	edent's Usual Occ ve kind of work don . DO NOT use reti	upation ne during most	of working	16b, Kind of Bus	iness/Industry
12	withir ane. than	g L	Elementary/Secondary (0-12)	College (1-4or 5	1+)	or of O			Salf-a	mployed
d 2	should be filed within 72 hours after death with the Marylar of Mental Hygiene. marked other than "natural", or items 23a or 28a-1 show matte event, the Medical Examiner must be notified as		17. Father's Name (First, Middle, Last)		DOC.	OI OI O		's Name (First, Middle		
an	d be antal ced o	To Be	Joseph Tully				Catl	herine Kl	leist.	
Maryland 21215-0036	2 should be filed w nand Mental Hygie is marked other t raumatic event, In	F	19a. Informant's Name/Relationship (7	ype, Print)	19b. Ma	iling Address (Stre		r or Rural Route Numb		State, Zip Code)
	D = 2.		Gail Owen	(Daught	ter) 214	Homewo	od Te	rrace Ba	ltimore	, MD. 21218
ē,	s 1 and 3 of Health item 27 other tra		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other p	(ace)	Date	20c. Location - 0	City or Town, State
Ë	Page ent o nt: If ry or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			rematio		8/4/05	Smyrna	, DE.
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature of June (al Service Linear			22. Name and Add	ress of Facility	,	e Chaml	an I Cabaad
m	Dep tmp any		Y ACC	1	$400510 \pm$	118 Wes	t Cros	ss St. Ga	ilena. N	nen L Schaech MD. 21635
			23a. Part1 Enter the disease, or companies, or heart failure. List only	lications that caused one cause on each lir	the death. Do not e	nter the mode of d	ying, such as o	cardiac or respiratory a	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Sclovetic					Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):					9
	LAdiminei	_	Sequentially list conditions,	b. Due to /or or o	a consequence of):					
,	ed isi	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence oi):					
•	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of);					-
760,	sician buris	caiE		d						
687	leath certificate b attending physic I for use as the b	edi		0.						
Вох	nding use a	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date	of delivery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		☐Ectopic pregnar ☐ Other (specify)	icy		Mont	th Day Year
P.0	The law requires that the death certifica te has been signed by the attending phoage 2 should be detached for use as it	Physician/M	9 🗆 Unknown	9□ Unknown						
	es that igned t	by F	Part II. Other significant conditions of	_	-		-			bute to the cause of death?
ord	w require been si should I	ted	18TN; Arthuitis						Yes 2□No 3	Probably 4 Unknown
Records,	e faw r has be je 2 sh	ompleted	Stonosis; Dysr	hytlimia	; BPH;	Peripher	ee Vas	CD 24a. Was	psy pr	fere autopsy findings available for to completion of cause of eath?
=		Con	Multiple TIA	<u>z</u>				1 Yes	ormed? de 2000 1 [atin? □Yes 2□No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Check only		
o	shys this at dia	2	1 ☐ Yes 202 No 27. Manner of Death	1 Inpatier	nt 2 ER/Outpat	ent 3 DOA	Nur	sing Home 5 Resi	idence 6 Gother how injury occurre	
	ding f h. After funer	tion	1 Pending 5 Pending	(Month, Day	Year) Injun	W	ork? □Yes 2□N		,,	
Division	or Attending after death. Director: After in by the fune	ertification:	3 Suicide 6 Could not be		ury - At home, farm, c. (Specify)	street, factory, office	θ	28f. Location (Street and Number	r or Rural Route Number,
D.	after after t Direct d in by	erti	4 Homicide	building, etc	c. (Specify)			City or To	wn, State)	
	To the Hospitat or within 24 hours after To the Funerat Directompletely filled in b	calC	29a. Certifier (Check only 2 Medical Exam	ysician: To the best of	of my knowledge, de	ath occurred at the	time, date and	I place, and due to the n occurred at the time,	cause(s) and man	ner as stated.
	the hin 24 the F	Medical	one)	and manner sta	ited.		nse number			(Month, Day, Year)
l.	To COL		29b. Signature and title of certifier	200			5070	3/	8/4/0	
,			10th S	2000)	(las 00 -) C		2010	16	-1110	
	421		30. Name and address of Neil Stoddard				Cheste	rtown, M	D. 2162	0
	Sta	te	31. Date filed (Month Day Year)	32. Posistra	ar's Signature	501		_ JOHILY II	2.02	~
	Registr		31. Date filed (Month, Sar, Year) AUG 1 0 2	U05 Maga	w K	market				

			1 - State of Maryland / [Department of Health and M Certificate of Death	fental Hyg	iene 2005	26305
	Dhusisi		1. Decedent's Name (First, Middle, Last)		2. Date of Deat	th Day Year	3. Time of Death
	Physici Medio/		Robin Denise Uttermohlen		July	26 2005	5:50 a ^M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			9912 Liberty Road 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	Frederick thday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Frede	
	uneral irector		1014 office	Yrs. Months Days Hours Min.	(Month, Day,	23 1961	place (State or Foreign ntry) MD
			Usual Residence of Decedent		TICLE CIT		
ırylan	a how	_	10a. State 10b. County 10c. City, Tow	n or Location			10d. Inside City Limits
e Ma	8a-f	Directo		erick			1 ☐ Yes 2X No
with t	Den.	D	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cou	ntry?
eath	ns 23	Funerai	9912 Liberty Road 11. Marital Status 12. Was Decedent Ever in U.S.	21701	ecity Yes or No-	USA 14. Race - Ameri	can Indian.
fter d	riten	Fun	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
Surs a	Evan	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🗽 No Specify:		Specify: W	hite
. I Z I S-UUSO within 72 hours after death with the Maryland	nato	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Business/Ir	
within 6	Pan We	mpi	Elementary/Secondary (0-12) College (1-4or 5+)			Carroll Co	-
De le	of other than natural, or items 23a or 28a-f show event, the Medical Examination must be notified at		17. Father's Name (First, Middle, Last)	Truck Driver	e (First, Middle, M	Roads Depa	rulent
Aaryland 2 should be file		o Be	Kenneth Haugh	Doris	Harrison	n	
ary shoul	mar	-		. Mailing Address (Street and Number or Run	al Route Number	, City or Town, State, Zij	o Code)
2 0 £			Robert J. Uttermohlen/husband 9	12 Liberty Road Fre	derick.	MD 21701	
es 1 g	r oth		20a Method of Disposition 20b. Place of	Disposition (Name of y, crematory or other place) 7/29/		20c. Location - City or T	own, State
Page 1	ant: h		'4 □ Donation 5 □ Other (Specify) Carro	l Cremation, Inc		Hampstead,	
permit. Pages 1:	Important: If Item 2 any injury or other once.		21. Signature of Juneral Service Licensee	Pritts Funeral Hor	ne and C	hapel, P.A.	21157
	-		23a. Part1. Ent-1 the dist ase, or complications that caused the death. Do shock, or hierth lure. List only one cause on each line.				IIIIfai Agi DafMagai
Phy	sician		Immediate Cause (Final disease or condition	astatic Breast	Canca	2. ju	Onset and Death
	ledical aminer		resulting in death) Due to (or as a consequence				
LAC		-	Sequentially list conditions, if any leading to immediate Due to (or as a consequence	of).			
pell	nsit	nin.	cause (Disease or injury	51).			
, execu	n and ial-tra	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence	of):		-	
ox ob/ou,	physician and the burial-transit	dicai	d				
riffica	ng ph as th	Medi	IF FEMALE:				
ath cer	attending p	ician/Me	23b. Was decedent pregnant in the past 12 months? 1□Live birth 2□Fetal death			23d. Date of deliv Month	ery Day Year
D. D.	the a	hysic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		, month	Day Tour
Ords, P.O	been signed by the should be detached	٥	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
Lires S	sign Id be	d by	None Knows		1 □ Ye	es 2 No 3 Pro	bably 4 Unknown
ິນ ≩	shou	ompieted			24a. Was a	n 24b. Were auto	opsy findings available
The ta	page 2	mo di			autops perforn	y prior to co ned? death?	impletion of cause of
	certificate rector, pag	C	25. Was case referred to medical	26. Place of Deat			2 110
09	this certific al director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Other: 4 Nursing Ho	me 5 Reside	ence 6 ☐ Other (Specia	(y)
ng Phy				Time of 28c. Injury at mjury Work?	28d. Describe ho	w injury occurred	
SIO tendi	tor: A the fu	cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
JIVISION Or Attending	Direc in by	Certification;	4 Homicide determined 28e. Place of Injury - At home, fa	rm, street, factory, office	28f. Location (Sti City or Town	reet and Number or Rura n, State)	al Route Number,
spital	filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge	death occurred at the time, date and place.	and due to the ca	suse(s) and manner as s	tated
DIVISION To the Hospital or Attending within 24 hours after death.	To the Funeral Director: After completely filled in by the funer	edicai	(Check only 2 Medical Examiner: On the basis of examination an one)	d/or investigation, in my opinion, death occurr	red at the time, da	ate and place, and due to	o the cause(s)
To th	To th comp	Me	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Month,	Day, Year)
	Th		Howard Sawit, M.P.	015552		7/26/05	
V	5		30. Name and address of person who completed cause of death (Item 23a)	Type, Print)	1 / 1	11. 21	10.5-
			11 Date fled Marth Day Vac	Type, Print) Ceuty Street	T Way	HIWEL , 1	1021157
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 7 2005 32. Refistrar's Signature	1			
	3.51		The second secon	MODICE			

-05	029		Please	ype or Prin					-	_	
M			_ For					lealth and Me			0.000
			1- State RegistraAmended #7an	d 8 as per	rFH,fc	hdCert	tificate of I	Death CM08	/04/05 Re	9. No Z U U 5	26306
	7 (1)	JA,	1. Decedent's Name (First, Middle, Last						Date of Death	1	3. Time of Death
	Physici	an	Johann E	tornam	Von	Ballm	oos		Month T1	Day Year 2005	1.4
	/Medic		As Facility Name (If and institution at a	-to-at and sumbool			4h City Town or	Location of Death	July	25 2005 4c. County of Dea	
	Examir	ner	4a. Facility Name (If not institution, give		_					l í	
Si		W.	Frederick Memoria				Freder			Freder	
1/2	, Funeral	73.5	5. Social Security Number 6. Se	x 7.Age StM 2□F	(In yrs. last	2.7.1.1.0.2.7.7	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Sept. 24,	Yela0 96 9. Bir	thplace (State or Foreign ountry)
4	Director		11/ a	&m 20 F	-9 8	Yrs.		9	sept. 24,	1996 Gha	na
	P .		Usual Residence of Decedent		40- Ch T						40d Jacida City Limite
	ehow		10a. State 10b. County		10c. City, To						10d. Inside City Limits
	W H	is	Maryland Frederic	ĸ	Fred	erick					1 ☐ Yes 2 🔀 No
	128	Directo	10e. Street and Number				10f. Zip Code		10	g. Citizen of What C	ountry?
	3a o	0	5829 Mercantile	Drive			2170	3		Ghana	
	ns 2	by Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W		ispanic Origin? (Spec an, Mexican, Puerto R	offy Yes or No-	14. Race - Am	
	iter o	Į,	1 TNever Married 2 Married	Armed Forces? 1 ☐ Yes 2 📆 N	0	If	Yes, specify Cuba	an, Mexican, Puerto R	lican, etc.)	Black, Whi	
36	rs af	Š	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2 🙀 No	Specify:		Specify: B	1ack
21215-0036	72 hours after death with the Maryland Insturel; or items 23s or 28s-f ehow Intel Extended must be notified at		15. Decedent's Edu		1 1	6a Decede	ent's Usual Occup	ation		6b. Kind of Business	s/Industry
ည်	72	ete	(Specify only highest grad	e completed)		(Give k	rind of work done	during most of working	9	. (
2	within ene. then.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	o. D	None	,		None	
	filed v Hygie other t	ပိ	4		Ì		None	18. Mother's Name	(Eint Middle A	foidan Cumama)	
ng	tal H d otl	Be	17. Father's Name (First, Middle, Last)						•		
<u>a</u>	ould be Mental Marked o	2	James Voi	n Ballmoos				Miria		Sowu	
Maryland	de E		19a. Informant's Name/Relationship (7)		1		,	and Number or Rural			Zip Code)
	permit. Pages 1 and 2 Department of Health a important: If item 27 is eny injury or other tra <u>90ce</u> .		James Von Ballmoos	/Father		5829 1	Mercanti	le Drive,	Frederi	ck, MD 2	1703
Baltimore,	te He other		20a. Method of Disposition		20b. Place	of Dispos	ition (Name of atory or other place		ite 2	Oc. Location - City or	Town, State
2	nt of		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		1		: Cemeter	1)5 Er	ederick,	Maryland
Ξ	rtme rtan njur		21. Signature of Funeral Service Ligens		7			ss of Facility Sta			*
Ba	Depa impo eny i		21. Signature of Furieral Service agents	10/1	1.			umtown Pik			
	TO 12 6 C		Allarow Clin	ulle Cl	me	1					T
4		-	23a. Part1. Enter the disease, or compi shock, or heart failure. List only o	ne cause on each lin	the death. L e.	o not ente	r the mode of dyin	ig, such as cardiac or	respiratory arre	St,	Approximate Interval Between Onset and Death
3	Physician		Immediate Cause (Final disease or condition	DROW	WI WG	_					Oliset and Death
4 4 1	/Medical		resulting in death)	Due to (or as a							
	Examiner										
		ē	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequen	ce of):					
	nsit	nin.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	be executed sictan and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequen	ce of):					
760,	e be ex sician e burial	calE									
87	leath certificate I attending physi i for use as the b	G		d							
89	ing F e as	Physician/Medi	IF FEMALE:								
Вох	th ce fend r us	an/	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth			Ectopic pregnancy	,		23d. Date of de Month	Blivery Day Year
	dea e at e at od fo	ici	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at t	time of death	5 🗆	Other (specify)			Wichter	Day Tour
P.0.	t the by th ache	hys	9 🗌 Unknown	3C OTKIOWIT	-						
	The law requires that the death certificate sie has been signed by the attending physoage 2 should be detached for use as the	by P	Part II. Other significant conditions co	ntributing to death bu	t not resultin	g in the und	derlying cause give	en in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
p	uire Signa Id bi	d b	AUTISM						1 ☐ Ye	s 2□No 3□P	robably 4 Inknown
Ö	w require been si	Completed							24a. Was an	24h Were 2	utoney findings available
ě	has 62	npi				<u> </u>			autopsy	prior to death?	utopsy findings available completion of cause of
<u> </u>	rsician: The law s certificate has t lirector, page 2 s	Ö							1 ¥Yes 2	□ No 1 XYe	s 2 No
<u>:</u>	ian: prtific ctor,	Be	25. Was case referred to medical examiner?					26. Place of Death	(Check only one	9)	
of Vital Records,	Physician: r this certificated director,	To	1 Ves 2 No	Hospitat: 1 ☐ Inpatier	nt 2 🔀 ER/	Outpatient/	3□ DOA Oth	er: 4 ☐ Nursing Hom	e 5 🗆 Reside	nce 6 Other (Spe	ecify)
0	eral eral		27. Manner of Death	28a. Date of Injun	y 28	b. Time of Injury	28c. Injun Wor	y at 21		w injury occurred	
0	ding F th. After funera	유	1 □ Natural 5 □ Pending 2 ☑ Accident investigation	FOUND 7/2		ND 3:30	2M 1□	Yes 2 XVo	WBTECT	HHIVE POL	
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his compilately filled in by the funeral director, page	Medical	one)	and manner stat	IOG.		On Linear	a number	. 14	d Date signed (44	th Day Voor
	To Too	2	29b. Signature and title of certifier				29c. Licens	9 HUITIUFF	29	d. Date signed (Mon	
			mell				OCN	Œ		July, 2	6, 2005
-	2		30. Name and address of person who co	ompleted cause of de	eath (Item 23	la) (Type, P	Print)				
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Registrar DHMH 17 Rev 1/2001

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ian ical	Beatrice	Marg	uerite	V	an Ger	nert			July	31.	, 200	Year)5	5:15 a.
ner	4a. Facility Name (If not institution,						Location	of Death	<u> </u>		c. County		13.13 4.
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To Be	Lars Michelse	on.							ederse				
-	19a. Informant's Name/Relationship			19b. Mailir	na Address	(Street a			al Route Num		or Town	State Zir	Code)
	Marcia van Geme	ert / Da	ughter						ort Re				
	20a. Method of Disposition	ore / Da	20b.	Place of Dispo	sition (Nam	ne of	_		Date Ne				own, State
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David J. Tardio, M.D.,

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Division of Vital Records, P.O. Box 68760,

110 Hospital Road, Prince Frederick, MD 20678

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	tural 5 Per inversion omicide 6 Cou dete	tural 5 Pending investigation dicide 6 Could not be determined 286 Could not be determined 286	r of Death dural 5 Pending investigation slicide 6 Could not be determined 28e. Place of Injury building, etc. Certifying Physician: To the best of earn manner state	r of Death tural 5 Pending investigation dicide omicide filer ix only 1 Impattent 2 EH/Ob. 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, fa building, etc. (Specify) 28e. Place of Injury - At home, fa building, etc. (Specify)	r of Death urral 5 Pending investigation sicide omicide omicide fier at Anny 2 Pending investigation sicide omicide The control of the con	r of Death tural 5 Pending investigation is cident or independent of the provided or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation or investigation, in my opinion or investigation o	r of Death tural 5 Pending investigation investigation cident determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Mork? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office	r of Death tural 5 Pending investigation is cident or independent of the provided building, etc. (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Pes 2 No 28d. Describe Now Now? 28d. Date of Injury at Work? 1 Pes 2 No 28d. Describe Now Now? 28d. Date of Injury at Work? 2 No 28d. Describe Now Now Now? 28d. Date of Injury at Work? 2 No 28d. Describe Now Now Now Now Now Now Now Now Now Now	r of Death tural 5 Pending investigation occident side of Enjury - At home, farm, street, factory, office 28f. Location (Street and Nucleic office) of Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and ture and unter of certifier 29f. License number 29d. Date significant occurred at the time, date and place and due to the cause(s) and sture and unter of certifier 29d. Date significant occurred at the time, date and place and due to the cause(s) and sand manner stated.	r of Death thursal 5 Pending investigation dicide omicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rundling) 28b. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rundling) 28f. Location (Street and Number or Rundli

RIAN W	IGG]	ENS	For State Registrar	State of	Marylar		artmen rtificate				-	_		
37		a	Hegistrar Decedent's Name (First, Middle, Las	t)				e or L	Jean		2. Date of De	ath	00.	3. Time of Death
	ysicia Jedic		Adrian G. Wiggir	ıs, Jr.							JULY	24, 20	05 ^{Year}	2:38 P ^M
	amin	er	4a Facility Name (If not institution, give WASHINGTON ADVEN)	CIST HOSE			TAI	KOMA	PARK			MON	ity of Death	1
Fun Dire	8	ii.	5. Social Security Number 6. Sec. 578–80–4290 1 Usual Residence of Decedent	7. M 2 F	Age (In yrs.	7 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	B Date of Bir (Month, Da Feb. 2	1958	9. Birth Con Wa	nplace (State or Foreign unity) LSh., DC
Maryland	lied at	tor	10a. State 10b. County DC		10c. Cit	ty, Town or Lo	ecation		Wash	ingt	on			10d. Inside City Limits 1 ₩ Yes 2 No
th the	e not	Oirec	10e. Street and Number				10f. Zip	Code				10g. Citizen o	f What Co	untry?
ath w	and t	rai		ion Ave.						019			Unite	d States
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural; or itema 23e or 28e-f show	Examiner	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date	EXNo		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Origon, Mexican Specity:		ecify Yes or No Rican, etc.)	Spec	ack, White	rican Indian, o, etc. Black
Maryland 21215-0036 Id 2 should be filed within 72 hours af th and Mental Plygiene. 27 Is marked other than "natural; or	Medical	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)		or 5+)	16a. Dece (Give life.	kind of wor DO NOT us	k done d se retired,	u <i>ring mosi</i>	t of worki	ng	16b. Kind of		
id 21 filed w Hygier other th	ut,	Co	12th 17. Father's Name (First, Middle, Last)					Roof		r'e Name	/First Middle	Maiden Suma		Employed
arylan should be and Mental	lic eve	To Be	Adrian Gaine	s Wiggir	ıs, Sr	•			TO. WICKING			Annet	/	len
lary	auma		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rura	l Route Numbe	er, City or Town	n, State, Z	ip Code)
e, N 1 and 1 and 1 and 1 and 1 and 1 and 1 and	ther tr	1	Adrian G. Wiggin	s, III-S		1304 Place of Dispo			age C		Rd., I	Laurel,		20708
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2	njury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ D tion 5 ☐ Other (Specify)	ıte C	enwood	Ceme	ther place tery		7/30	/2005	20c. Location	h., D	
Derin Department	eny i		21. Signature of Funeral Service Licens	Luga	ut T	1/ 22	4001			SL		Funeral Vash.,		
Physic			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on eac	n line.		er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,	DO 20	Approximate Interval Between Onset and Death
/Medi Exami	ner			Due to (87	as a conseq	uence of): Venous	s the	ont	osis		pembol			
rted	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):								
or 68 /60, certificate be executed ding physician and		icai Exa	that initiated events resulting in death) Last	Due to (or	as a conseq	uence of):								
C 68 artifica ing ph			IF FEMALE:											
Geath death	ached for us	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcor 1□Live birth 4□Pregnant 9□Unknowr	2 ☐ Feta at time of d	I death 3	Ectopic pre Other (spe						ate of deliv Ionth	rery Day Year
S, resthandigned	e	ò	Part II. Other significant conditions co	ntributing to death	but not res	ulting in the ur	nderlying ca	iuse give	n in Part I.		23e. Did to	1/		the cause of death?
The The	page 2	Completed							-				prior to co	opsy findings available ompletion of cause of
OT VITAL Physician: The this certificate	irector,	0	25. Was case referred to medical examiner?	Hospital:	VZV	7		Othe			Check only o	70	•	
	<u> </u>	0 1:	1 X Yes 2 No 27. Manner of Death	1 Inpa		ER/Outpatien 28b. Time of	-	Bc. Injury Work	4 🗆 1901			lence 6 Ot		fy)
VISION Attending	the Tuner	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, I	Day Year)	Injury	м		? es 2 ☐ N	40				
DIVISION ital or Attending its after death.	titled in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of building,	Injury - At ho etc. (Specify	ome, farm, stre	eet, factory,	office		2	8f. Location (S City or Ton	Street and Num vn, State)	ber or Run	al Route Number,
DIVISION To the Hospital or Atten within 24 hours after deat To the Funeral Director.	oletely	Medical	29a. Certifier (Critical visit) (Critic	sicien: To the be ner: On the basis and manner	oi examina	wledge, death tion and/or inv	estigation,	in my opi	nion, deat	d place, a	ed at the time, o	date and place	, and due t	o the cause(s)
Town	oo l		29b. Signature and title of certifier Panati Bouthy	U. MD				O.C	.M.E			29d. Date signi JULY	ed (<i>Month,</i> 25, 2	
1(3)			30. Name and address of person who co	ompleted cause o	f death (Item 11	23a) (Type, I 1 PENN	STRE	ET,	BALTI	MORE	, MARYL	AND 212	01	
	Stat	~	31. Date filed (Month, Day, Year)	. Regi	strar's Signa	ture /								
DHMH 17 Re	gistra ev 1/200	4.	ገበΓ % ል ናሰ ሰ ጋ	Down	1	April		_						

DHMH 17 Rev 1/2001

ORIGINAL

Physic	ian	1. Decedent's Name (First, Middle, L	,					2. Date of D	Da	ay Coop	ear	3. Time of Death
/Medi	cal	Tabitha Ann Wrig			45.0	the me		JULY		2005		2247 P
Exami	ner	FREDERICK MEMOR		AT.		REDERIC	ocation of Deat K	'n	1	c. County of FREDE		
Funeral					last birthday) If Ur	ider 1 Year	f Under 24 Hrs	8. Date of Bi	irth			ice (State or Fore
Director		214-73-8988	1□M 2⊠F		Yrs. Mont	hs Days	Hours Min.	July 6) 15 1	Countr Mary.	land
3 22		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Location						10	d Incide City Lim
f ehow	ō										10	d. Inside City Lim 1- Yes 2□
a or 28a-f ehow be notified at	Director	Maryland Freder: 10e. Street and Number	LCK	rr	ederick	Zip Code			10n. C	itizen of Wha	at Countr	
ms 23a or 28a-f ehow	i D	1090 Greenwall P	Lace, Apt.	2B		21703			_	ted St		•
ems 2	Funerail	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13. Was De	cedent of Hisp	anic Origin? (S	Specify Yes or N to Rican, etc.)		14. Race -	America	n Indian,
or It	y Fu	1X Never Married 2☐ Married	1 ☐ Yes 2√☐	Vo			Specify:	to Alcali, etc.)		Specify: V	White, e	
ene. than "natural", or Ite ne Medical Exemine	d by	3 Widowed 4 Divorced	Year or Dates:			107						
"nat	iete	15. Decedent's (Specify only highest g	rade completed)		16a. Decedent's U (Give kind of life DO NO	Isual Occupation work done dur Tuse retired)	on ing most of wo	rking	16b. F	Kind of Busin	iess/Indu	istry
ther.	Completed	Elementary/Secondary (0-12)	College (1-4or :	5+)	None	, , , , , , , , , , , , , , , , , , , ,				None		
ital Hygiene. Id other then event, the M	Be C	17. Father's Name (First, Middle, Las	st)			18	3. Mother's Nar	me (First, Middle	, Maidei			
markad o	To E	William Wright				J	oanna I	Kurlowic	h			
of Health and Ment litem 27 is marked r other trsumatic e	ľ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing Addr	ess (Street and	Number or Ru	ural Route Numb	er, City	or Town, Sta	ite, Zip C	Code)
m 27		William Wright/F	ather		1090 Gree		Place A		-			
		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from State	20b. F	Place of Disposition (semetery, crematory	Name of or other place)		Date	20c. L	ocation - Cit	y or Tow	n, State
Department Important: I any injury c		4 Donation 5 Other (Spec		Mt	. Olivet			4/2005	Fre	derick	, Ma	ryland
Department Important: Important: I any injury o		21. Signature of Funeral Service Lice Bandles 1 x	wife		1621	Opossur	ntown P	auffer like, Fre	Fune: eder:	ral Ho ick, M	me, D 21	P.A. 702
bysician and publician and publician strip prize transit strip pri prize transit strip prize transit strip prize transit strip	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.	a conseq a conseq	uence of):	ndrome(2102)					
ed by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	I death 3 □Ectopie	pregnancy (specify)				23d. Date o Month		r lay Year
igned b	by Pi	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the underlyin	g cause given	n Part I.	23e. Did	tobacco	use contribu	te to the	cause of death?
been sig	ed							1 🗆	Yes 2	□No 3[Probat	oly 4 Unkno
certificate has be irector, page 2 sh	Completed									dea	PT?	iy findings availal pletion of cause o
certifica rector, J	Be	25. Was case referred to medical examiner?				2	5. Place of Dea	ath (Check only				
- S	101	Yes 2□ No	Hospital: 1 Inpatie	nt 2X	ER/Outpatient 3□	DOA Other:	4 Nursing H	lome 5 ☐ Resi	idence	6 □Other (Specify)	
ath. r: After th ie funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe	how inju	ry occurred		- Carallana - Cara
within 24 hours after death To the Funeral Director: \ completely filled in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	be co- Di	ury - At ho	ome, farm, street, fac		3 2 □ No	28f. Location (City or To	Street ar wn, State	nd Number o	or Rural F	Route Number,
24 hours • Funera letely fille	Medical C	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☑ Medical Exa	hysician. To the best	examina	wledge, death occurr tion and/or investigat	ed at the time, ion, in my opini	date and place on, death occu	, and due to the irred at the time,	cause(s date and) and manne d place, and	er as stat	ed. ne cause(s)
withir To th comp.	Me	29b. Signature and title of certifier	11			29c. License n	umber		29d. Da	ite signed (M	fonth, Da	ay, Year)
		· M	3/			OCM	Œ	}	JŪI	Y, 3	1; 2	005
	i L		and the		n 23a) (Type, Print)					-		

			For Stete	State of	Maryland /	•	rtment of H			giene	
	20		Registrar 1. Decedent's Name (First, Middle)	le, Last)			inouto or i		2. Date of De		3. Firms of Deat
	Physicia			Waters					Month July	26, 2005	2:30 P M
	/Medic Examin		4a. Facility Name (If not institution		ber)		4b. City, Town, or	Location of Dea		4c. County of Dea	
		eı	13114 Wilton Oa				Silver S	Spring		Montgomer	ÿ
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. last t	birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Bir		
	Director		577-36-9680	1 X M 2□ F	75	Yrs.	Months Days	Hours Min	Jun 17	, 1930 Wash	thplace (State or Foreign buntry) aington, D.C.
	ס		Usual Residence of Decedent					1			
	rylan how	_	10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits
	e Ma	cto	Maryland Montgo	omery	Silver	Spr	ing				1 ☐ Yes 2 🛣 No
	or 26	Oire	10e. Street and Number				10f. Zip Code			10g. Citizen of What Co	ountry?
	23a	Funeral Director	13114 Wilton Oa	aks Drive			20906			USA	
	ams err	ine	11. Marital Status	Armed Ford		13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (in, Mexican, Pue	Specify Yes or No orto Rican, etc.)	14. Race - Ame Black, Whi	
36	or It	y FL	1 ☐ Never Married 2X Mar	ried 1X Yes 2 If Yes, Give	2 □ No les:1947 - 57	. 1	☐ Yes 2X No	Specify:		Snecify:	cican
ë	ural',	d by	3 Widowed 4 Divorced					-41			erican
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show tha Medical Examinar must be mutifled at	Completed		nt's Education est grade completed)	16	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	during most of w	orking	16b. Kind of Business	rindustry
12	withii ane. than	dwo	Elementary/Secondary (0-12)	College (1-		apta		,		U.S. Capit	al Police
2	be filed ntal Hygie ad othar avant.		17. Father's Name (First, Middle,	Last)		apca	111	18. Mother's N	ame (First, Middle	, Maiden Sumame)	ar rorree
an	d be antal) Be	William Leon Wa						bel Harl		
Maryland	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. markad othar than "natural", or Itams 23a or 28a-f show imatic avant. The Medical Examiner must be mulified at	은	19a. Informant's Name/Relations		19	9b. Mailin	a Address (Street a			er, City or Town, State,	Zip Code)
<u>s</u>	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is markad any injury or othar traumatic as onca.		Doris F. Waters							r Spring, M	
စ်	Heal Heal tem		20a. Method of Disposition		20b. Place		sition (Name of natory or other place		Date	20c. Location - City or	
altimore,	ages int of t: If it		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S		late			00	11y 28,		0000 ¥ =0000¥
Ξ	artme ortan injur	l	21. Signature of Funeral Service		W. Ar	unde	 Cremato Name and Address 	ss of Facility	2005	Odenton, Ma	ryland
Ba	permi Depar Impor any ir		Banklet	11-01-16	MO125	Go	ing Home	Cremáti	on Servi	ce P.O. Bo	x 784
			23a. Part1. Enter the disease, o	r complications that ca							e. MD 21029
	_		shock, or heart failure. List Immediate Cause (Final	only one cause on ea	ch line.				,	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Pane		T Co	neer			43 months
	Examiner			Due to (o	r as a consequenc	e of):					
		ra la	Sequentially list conditions, if any, leading to immediate	b	or as a consequenc	e of):					
	nsit	min	Cause (Disease or injury	<							
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (c	or as a consequenc	e of):					
760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit	icai		d							
89	ificate g phys	edic									
Box	eath certifica attending pl for use as t	N	1F FEMALE: 23b. Was decedent pregnant		ome of pregnancy		1=			23d. Date of de	livery
Ď	death e atte d for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□ Pregna	th 2 Fetal dea int at time of death		Ectopic pregnancy Other <i>(specify)</i>	·		Month	Day Year
o.	t the by the ache	hys	9 Unknown	9□ Unknov	wn						
ري ص	res that the de signed by the a be detached f	by P	Part II. Other significant conditi	ons contributing to dea	ath but not resulting	g in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Records,	w require been sig should b								1 🗆	Yes 2□No 3□P	robably 4 Unknown
၀	s bee	olet							24a. Was	an 24b. Were a	utopsy findings available
æ	The la	Completed							auto perfo	ormed? death?	completion of cause of
Division of Vital	sician: The law certificate has b irector, page 2 s	a	25. Was case referred to medica	al				26. Place of D	eath (Check only o		7,2110
\geq	Attanding Physician: r death. sctor; After this certifics by the funeral director, p	OB	examiner? 1 □ Yes 2 XNo	Hospital: 1 ☐ In	patient 2 ER/0	Outpatien	t 3 DOA Oth	er: 4 🗌 Nursing	Home 5 Resi	dence 6 Other (Spe	cify)
0	g Ph er th	n; T	27. Manner of Death	28a. Date of	f Injury 28b	. Time of				how injury occurred	
<u>o</u>	ath. r: Aft	atio	1 Matural 5 ☐ Pendid 2 ☐ Accident invest	igation (Month)	, buy /ou/	injury		Yes 2□No			
<u> </u>	Atta er de racto by th	ertification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ningd 200. Place	of Injury - At home, g, etc. (Specify)	farm, str	eet, factory, office		28f. Location (City or To	Street and Number or R wn. State)	ural Route Number,
	Hospital or Attanding Physician: The I 24 hours after death. Funaral Diractor: Atter this certificate ha tely filled in by the funeral director, page	Cer			3, (-,, /,						
	lospi I hou unar	cal	29a. Certifier 1 Certifyi	ng Physician: To the I	best of my knowled	dge, death	occurred at the tin	ne, date and pla	ce, and due to the	cause(s) and manner as date and place, and due	s stated.
	To the Hospital or within 24 hours after To the Funaral Dit completely filled in	Medical	one)	and mann	er stated.						
	To To com	2	29b. Signature and title of certifie	or O			29c. Licens	e number		29d. Date signed (Mont	n, ∪ay, rear)
	~		Paul	Barre			MOO	6033	5	July 2	7,2005
+1	ad		30. Name and address of person	who completed cause	of death (Item 23a	a) (Type,	Print)	Pa	ul Barner	July 2 20832	,
_		12.0	18111	Prince	Philip	Pri	e #32	7 06	icy, MD	20832	
	Sta Registr		31. Date filed (Month, Day, Year	0 200E 32. Re	strar's Signature	20			*		
	negisti	ul	JUL Z	9 2005	Meser D	6	becks				

			For State Registrar	tate of Maryland			t of Healt e of Dea			jiene	005	, m
	Physici	an	Decedent's Name (First, Middle, Last)	ES STEPHEN	WDTC	ייינו			2. Date of Dea Month		Year ○ ≤	3/Time of Death 2
	/Medic Examir		4a. Facility Name (If not institution, give stre UNION MEMORIAL HO	et and number)	WRIG	4b. City,	Town, or Locat		JULY	4c. Cou	nty of Death	20.05
	Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. I.	ast birthday) Yrs.	If Under Months		der 24 Hrs.	8. Date of Birth (Month, Day N . 7	Year) 1928	9. Birthp Coun DUBL	
	Maryland -f show	tor	10a. State 10b. County MD CARRO		, Town or Lo		R				10	0d. Inside City Limits
	h with the 13a or 28a	Funeral Director	10e. Street and Number	REET		10f. Zip			1	0g. Citizen	of What Coun	itry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinant the reciliad at once.	þ	11. Marital Status 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Deced If Yes, spec 1 ☐ Yes 2	ify Cuban, Mex	cican, Puerto F	cify Yes or No- lican, etc.)	E	Race - America Black, White, e	etc.
21215-0036	within 72 hor ene. then "natura he Medical E	Completed	15. Decedent's Educati (Specify only highest grade or Elementary/Secondary (0·12)		(Give life.	kind of wor DO NOT us	I Occupation of done during to retired)		g		f Business/Ind	dustry
Maryland 2	uld be filed Mental Hygid Irkad other Itic event, I	To Be Co	17. Father's Name (First, Middle, Last) IRVIN WOOD V		MIT	DICK	18. M	lother's Name	(First, Middle, KELLY			(IDI
	l and 2 sho lealth and I im 27 is me her traume		19a. Informant's Name/Relationship (Туре, MARY L. WRIGHT –	WIFE	100	N. (CENTER	ST.	Route Number	INST	ER, MI	21157
altimore,	it. Pages 1 rtment of H rtant: If ite njury or ot		20a. Method of Disposition Typ Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	lace of Dispo emetery, crea OW BR	ANCH	CEM.	AULY :			on - City or To	NSTER, MD
■ Ba	Depar Impor any ir		21. Signature of Funeral Service Licensee	ions that caused the death	91	MYER 91 W	ILLIS	SOŘAW 1	FUNERA ESTMIN	STER,		.A. 21157 Approximate
	Physician /Medical Examiner		sholk, or heart failure. List only one of the control of the contr	Due to (or as a consequ	עמ	euw.	3					Interval Between Onset and Death
8760,	iicate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last d.	Due to (or as a consequ						-		
.O. Box 6	the death certil y the attending sched for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregna. 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pro		-			Date of delive Month	ory Day Year
rds, P	sign sign d be	by	Part (I. Other significant conditions contrib	outing to death but not resu	ulting in the u	nderlying ca	ause given in P	art I.		bacco use co es 2□No		ably 4 Donknown
Vital Records,	(0	Completed							24a. Was a autops perform	Sy .	prior to con death?	psy findings available inpletion of cause of
of	ding Phye J. After this funeral dir	tlon; To Be	TETTES ZEINO	pital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		Other	Nursing Hom	Check on y on e 5 Reside	ence 6 🗆 (')
Division	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification;	3 Suiside 6 Could not be	28e. Place of Injury - At ho building, etc. <i>(Specif</i> y		reet, factory			Bf. Location (Si City or Town		mber or Rura	l Route Number,
	the Hospital or iin 24 hours afte the Funeral Dire	edical	one) 2 Medical Examiner	an: To the best of my know: On the basis of examinat and manner stated.	wledge, deat tion and/or in	vestigation,	in my opinion,	death occurre	nd due to the c d at the time, d	ause(s) and ate and plac	manner as sto e, and due to	ated. the cause(s)
)	M3/	M	29b. Signature and title of certifier	aemo		1	License numb	1028		9d. Date sig	7 S	Day, Year)
	Sta	ate	30. Name and address of person who comp AUE (AU) 31. Date filed (Month, Day, Year)	oleted cause of death (Item APA MO 32. Registrar's Signal	DEP	OFI	EDIUN	21 NE	Baltun	st U	MO 2	7 Pwg
	Regist		JUL 2 2 20		K	South	19					

			For State	State of M	1arylan					and Mo		-	വന		00010
			Registrar 1. Decedent's Name (First, Middle, Last)			Cei	uncai	e or L	Death		2. Date of Dea		005	1	26313
п	Physici	an	Phyllis Idel		ven						Month July	Day 23	200	F.	3. Time of Death 11:15 A M
	/Medic		4a. Facility Name (If not institution, give				4h City	Town or	Location o	f Dooth	July		County of D		11:15 A
	Examin	er	Brinton Woods Nu:						ville	n Death		40.	Carr		
	Euparal		5. Social Security Number 6. Sec			last birthday)	If Unde	r 1 Year	If Under 2	24 Hrs.	8. Date of Birth	1			ace (State or Foreign
	Funeral Director]M 2 ∑ F	74	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day July 2	Year)	931	Count	ace (State or Foreign TV) V Jersey
	D		Usual Residence of Decedent								001)	-, -			
	how thow	_	10a. State 10b. County	1	10c. Cit	y, Town or Lo								10	d. Inside City Limits
	89-1.8	cto	Maryland Carrol	1		Sykes	SVILL	.e							1 ☐ Yes 2 🛣 No
	ith th	Dire	10e. Street and Number				10f. Zig	o Code					zen of What		-
	ath v	rai		oad					1784				ted S		
	er de	une		12. Was Deceder Armed Forces	6?	.S. 13.	Was Dece f Yes, spe	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	'	I4. Race - A Black, W		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates			1 🗆 Yes	2 🔯 No	Specify:				Specify:	√hi!	te
21215-0036	72 hours after death with the Maryland netural', or Items 23e or 28e-f show dical Exist direct out but calified at	Completed by Funeral Director	15. Decedent's Edu	cation		16a. Dece	dent's Usu	al Occupa	ation	_		16b. Kir	nd of Busine		
215	nin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4o	r 5±\	(Give	kind of wo DO NOT u	ork done d ise retired	luring most)	of workin	ig				,
21	d with	E O	7th	College (1-40		Hot	ısewi	.fe				0	wn Ho	me	
	al Hy al Hy foth	Be (17. Father's Name (First, Middle, Last)								(First, Middle,		,		
<u> </u>	Ment Ment	2	Thomas Heft							Mildı		Watk			
Maryland	and and ls m		19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailir	ng Address	s (Street a	and Numbe		Route Numbe			e, Zip (Code)
	and lealth m 27 her tr			Daughter	001 5	624			Road		esville				
O	ges 1		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F	Removal from Stat	_ 0	Place of Dispo	natory or o	other place			ate		cation - City		
Baltimore,	t. Partmentent:		'4 □ Donation 5 □ Other (Specify)		Sot						Ly 26,		•		
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23e or 28e-f show amy origing to other traumatic event, Ira Medical Exaction or other traumatic event, Ira Medical Exaction or other traumatic event, Ira Medical Exaction or other traumatic event, Ira Medical Exaction or other traumatic event, Ira Medical Exaction or other traumatic event, Ira Medical Exaction or other traumatic event, Ira Medical Exaction or other traumatic events.		21. Signature of Funeral Service Licens	Carro	7	B ₁	urrie 212 W	r-Qu . 01	een F d Lib	unera erty	al Home Road	& C Winf	remat ield,	ory MD	, PA 21784
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of	ications that caus	ed the deat line.										Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. (Obstection		-							Onset and Death ZYRS
	/Medical Examiner		resulting in death)	Due to (or a	is a conseq	uence of):	,)							
	Examine	_	Sequentially list conditions,	b											
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a conseq	uence ot):									
	xecul and al-trar	xan	that initiated events resulting in death) Last	Due to (or a	is a conseq	uence of);								-	
8760,	eath certificate be executed attending physician and for use as the burial-transit	icai E	L.												
687	ficate p physics ts the			J											
Вох	nding use a	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of <u>pr</u> egna	ancy						2	3d. Date of	deliver	v
	death e atten ed for u	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 4□Pregnant	at time of d]Ectopic p] Other (s _t						Month		Day Year
P.0	that the de led by the a detached t	Physician/Med	9 🗆 Unknown	9□ Unknown											
	S 15 00	by P	Part II. Other significant conditions con	ntributing to death	but not res	ulting in the u	nderlying o	cause give	n in Part I.			/	se contribut	e to the	cause of death?
Records,	w require been sig should b	Completed by									1 🖫 🛚	es 2]No 3□	Proba	bly 4 □Unknown
ecc	aw Is b	pie									24a. Was a		24b. Were	autop	sy findings available pletion of cause of
E.	ate pag	Con									perfor	med? 2 D No	death	1?	₽ III No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	I 't - I						of Death	(Check only o	ne)			
of	this cal dir	٦.	TO THE ZEMNO	lospital: 1 ☐ Inpa		ER/Outpatier			4 LINU		ne 5 Resid			pecify)	
n	fter file	ion	27. Manner of Death 1 DNatural 5 □ Pending	28a. Date of In (Month, D	Jury Day Year)	28b. Time o Injury	м	28c. Injury Work	at :? /es 2 □ l		8d. Describe h	ow injury	occurred /		
Division of	Attending r death. ector: After by the fune	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of I	niuw - At h	ome farm str			185 2 🔲		8f Location /S	treet and	Number or	Rural	Route Number,
Ο̈́	after after Dire	Certification;	4 Homicide determined	001, 120101	y, omoo		-	City or Tow	n, State)		7.0747	, route traineer,			
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	29a. Certifier 29a. Certifier (Check only (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred the time, date and place (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred to the control of the cont								d place, a	nd due to the o	ause(s)	and manner	as sta	ited. the cause(s)
	ithin 2 of the	one) 29b. Signature and title of certifier 29b. Signature and title of certifier							number				signed (M		
		Votano										2/	5/nc		-,. :/
	MJL	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										7/6	-103		
	3		1. 14	NOS MD	acaut (IIdi	1000	LIRE	RTY	RD	E	-Densis	UEG	as)	2	1784
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	ature									· v /
	Registi	ar	JUL 2 6 2	005	Seco .	K	Land								

		1	For State Registrar	State of Ma			of Health an	d Mental Hy	giene	005	26314
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	zig gerbs	2/		·	2. Date of De Month	ath	Year (OS	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s	street and number) Sept		WE	own, or Location of D			County of Death	
	Funeral Director		5. Social Security Number 214-14-8829 Usual Residence of Decedent	7. Ag ⊈M 2□F	e (In yrs. last birthda 86 Yrs.	(y) If Under 1 Months		Hrs. 8. Date of Bir Min. (Month, Date of Bir 5/27/	th ay, Year) 1919	9. Birth Cou MAR	place (State or Foreign ntry) YLAND
	e Maryland ta-f ehow	ctor	MD 10b. County CARRO)LL	10c. City, Town or WESTN	Location INSTE	ZR				10d. Inside City Limits 1 ☐ Yes 2 X No
	3a or 26	Il Director	10e. Street and Number 1047 HOOK RD.			10f. Zip C	21157		10g. Cit	izen of What Cou	ntry?
036	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If Itam 27 ie marked other then "natural", or Itama 23a or 28a-f ehow or other traumatic event, the Madical Examiner must be notified at	by Funeral		12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13		ent of Hispanic Origin' fy Cuban, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)		14. Race - Ameri Black, White, Specify: WHI	etc.
21215-0036	within 72 ho iene. 'then "natur ithe Modical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2		(Gir iife	. DO NOT use	done during most of	working		ind of Business/In	dustry
Maryland 2	S should be filed within and Mental Hygiene. Ie marked other then aumatic event, IDE M.	To Be Co	17. Father's Name (First, Middle, Last) HEN	RY	WEISGE			Name (First, Middle	, Maiden		
Mary	and 2 sho Balth and I n 27 le ma		19a. Informant's Name/Relationship (Ty) GERTRUDE E. WEI				Street and Number of				·
Baltimore,	permit. Pages 1 an Department of Heal important: If Itam 2 any Injury or othar once.		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	omoval from State	20b. Place of Dis cemetery, ci	position (Name ematory or oth		Date	20c. Lo	ocation - City or To	own, State
Balti	permit. Departm imports any Inju		21 Signa Pa o Final I Service License			22. Name and	Address of Facility E	FLETCHER	FUI	NERAL H	OME
	Physician		23a. Parti. Enter the disease, or complishock, or beart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused be cause on each li	186.	ia		diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	ner	Sequentially list conditions, if any, leading to mineufacte cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	en l	bolien				Days
8760,	ate be executed by sician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):						
.O. Box 68	death certific e attending p od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	☐Ectopic preg				23d. Date of delive Month	ery Day Year
<u>α</u>	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant conditions con	tributing to death b	ut not resulting in the	underlying cau	use given in Part I.	23e. Did 1		_	he cause of death?
Il Records,	CO ton	Completed						24a. Was auto perfo		24b. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital:	-1 0/□ED/0.45-45	05 504	Othor	Death (Check only		2 CO11 - 12	. 8 118523
ion of	fe e	ation: To	27. Manner of Death 1 Patrial 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		of 280	c. Injury at Work? 1 Yes 2 No	g Home 5 Resi 28d. Describe			γ)
Division	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injuding, et	ury - At home, farm, s c. (Specify)	street, factory,	office	28f. Location (City or To		d Number or Rura)	al Route Number,
	n 24 hou ne Fune oletely fi	Medical	(Check only 2 Medical Examir	er: On the basis of	examination and/or	investigation, in	t the time, date and pl in my opinion, death o	ccurred at the time.	date and	place, and due to	the cause(s)
ì		W	29b. Signature and title of confifier			29c. I	License number		29d. Dat	e signed (Month,	Day, Year)
	MZZZA		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type	e, Print)	20 = :	,	71	1515	
	Sta		29b. Signature and title of coefficier 30. Name and address of person who coefficien 31. Date filed (Month, Day, Year)	295 51 32. Registra	ar's Signature	1-05+	- 507 CC	ectorins	re	MO	21157
	Registr	ar	JUL 2 7 2	1105	live to	Brack.	,				

		4	For State Registrar	State o	f Marylan	•	artment of H		Mental Hy	giene	005	26315
	2 Bu yo 4	w.	Decedent's Name (First, Middle,	Last)	-				2. Date of D	eath		3. Time of Death
	Physici		John DeS	ales	Wood				Julv	29, 20	Year 005	5:50 p.m.
	/Medic		4a. Facility Name (If not institution,				4b. City, Town, or	Location of Dea			ounty of Death	
	Examili	er	St. Mary's Nur								t. Mar	
1		~		Sing Cen	7. Age (In yrs.	last birthday)	Leon If Under 1 Year	ardtown If Under 24 Hr	s. 8. Date of B n. (Month, D		9. Birth	place (State or Foreign
	Funeral Director		213-22-0723	1 ∕ M 2□ F	79	V	Months Days	Hours Mir	July 1	ay, Year) 5. 19 2	Cou	yland
185	2(3)		Usual Residence of Decedent						July 1	J, 172	O ILCL	y zarra
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Mar.	ģ	Maryland St.	Mary's			Ridg	e				1 ☐ Yes 2 No
	r 28s	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	intry?
	death with the Maryland ms 23a or 28s-1 ehow Emust be notified at		13425 Point Lo	okout Roa	he		2	0680		Uni	ted St	ates
	me 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of Hi If Yes, specify Cuba		(Specify Yes or N		. Race - Ameri	ican Indian,
٥	after or ite	큔	1 Never Married 2 Marrie	Armed Fo	2 🖀 No		24211		эпо мсап, всс.)		Black, White,	
3	hours after urel', or Ite	þ	3 Widowed 4 Divorced	If Yes, Gir Year or C	ve Dates:		1 ☐ Yes 2 6 No	Specify:		Sp	рес <i>ify:</i> W.	hite
9500-6121	72 hc	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Occupa	ation	orkina	16b. Kind	of 8usiness/li	ndustry
Z	thin the	ple.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	571111g			
N	ar th	lo:	8			B1	cick Maso				onstru	ction
פ	be filed within 72 hours after death with the Marylan ital Hygleine. Id other than "neturel", or liems 23a or 28s-1 show event, I've Madical Examinar must be notified at	Be (17. Father's Name (First, Middle, L.	ast)				18. Mother's N	ame (First, Middl	e, Maiden Su	ımame)	
<u>a</u>		70	Harry Eugene W	ood				Kathei	rine Hat	tie Mc	Kay	
Maryland	d 2 should th and Mer 7 le marke traumatic		19a. Informant's Name/Relationship	ip (Type, Print)		19b. Maili	ng Address (Street	and Number or I	Rural Route Num	ber, City or T	own, State, Zi	p Code)
_	and 2 ealth n 27 I		Pamela G. Cole	/ Niece		19575	Three No	otch Roa	ad, Lexi	ngton	Park,	MD 20653
altımore,	-155		20a. Method of Disposition	2 D 2		Place of Disponentery, crea	osition (Name of matory or other place	:е)	Date	20c. Loca	ition - City or T	own, State
Ĕ	Pages nert of int: If It		1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.			Micha	el's Cem.	8-2	-2005	Ridge	e, Mary	land
ᆵ	permit. Pag Department Important: I any Injury o		21. Signal of Janeral Service	ice see	7				Brinsfie	1d Fur	ieral H	ome, P.A.
ñ	P S F S G		Edward N. Brins	field, J	r. MO	0052 2	2955 но11	wwood R	oad Lac	nardto	TETAL II	20650-0279
	7		23a, Part1, Enter the disease, or o	complications that	caused the deat	h. Do not en	ter the mode of dyin	ig, such as cardi	ian or respiratory	arrest,	/WII 5 11D	Approximate
	Dhusisian		shock, or heart failure. List of Immediate Cause (Final	nry one cause on e	each line	(-//2	J= 1	1.00			Interval 8etween On, et and D, ath
	Physician /Medical		disease or condition resulting in death)	aDue to	(or as Jonsed	JOS of N	acoxy	Jun	www	>		MX.
	Examiner			Due to	(or as conseq	Jaar	1 nd H	DANT	tal	INA		agus
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a senseq	uen a of):	MEAL		Signa			X
	nsit	Examiner	Cause (Disease or injury	•	(Va	AD	- >	ومهد الهدادا	WAT			4/1
	al-tra	Xai	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uenc of):	a you	Office.	2104			4/-
8760	cate be executed physicien and the burial-transit	a					(1	\parallel	- 1			
89	ficate phy: s the	edical		0.			6/					
ŏ	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, ou	itcome of pregna	ancy				23	d. Date of deliv	/Arv
ğ	atter	clar	23b. Was decedent pregnant in the past 12 months?		birth 2 ☐ Feta nant at time of d		∃Ectopic pregnancy ∃ Other <i>(specify)</i>	1			Month	Day Year
o	the d	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr			_ c.i.i.a. (open.y)					
ع.	res that the de signed by the a be detached f	P	Part II. Other significant condition	ns contributing to c	leath but not res	sulting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
Records,	urres sign	d by							1]Yes 2□	No 3□Pro	bably 4. Unknown
Ö	w requ	Completed			1	M.	0		-			
Şe c	The taw sete has b page 2 s	idu				-,()	Til)		24a. Wa	opsy formed?	prior to co death?	opsy findings available ompletion of cause of
	: The cete hi	Ö							1 ☐ Yes			2 No
Vital	Physiclan: Th rthis certificete ral director, pag	Be	25. Was case referred to medical examiner?	II iv-t			1.5		eath (Check only	one)		
	Physic this c	2	1 ☐ Yes 24 No			ER/Outpatie		4 Mariyurshiy	Home 5□Re			ıfy)
ב	ding F. After Aunere	0	27. Manner of Death 1 ∰Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	Wor		28d. Describe	how injury	occurred	
Sio	death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could n	ot be				Yes 2 □ No				
Division of	or Att after d Direct in by	Certification:	4 Homicide determine	200. Place	e of Injury - At h ling, etc. <i>(Specil</i>	ome, farm, st fy)	reet, factory, office			(Street and i own, State)	Number or Rui	ral Route Number,
	ral D											
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical	(Check only 2 Medical E	xaminer: On the b	pasis of examina	ow/adgia, dati ation and/or in	h consumed at the two exestigation, in my o	ne date and pla pinion, death oc	ice, and due to the curred at the time	e dauea(e) and p	lace, and due	to the cause(s)
	the the	Med	one)	and mar	er stated.				· · · · · · · · · · · · · · · · · · ·			
	Twit To	-	29b. Signature and title of certifier	0 /	1 /	_ //	29c. Licens	number	110	Zed. Date	signed (Month	, way, rear)
	CAR		Jen	MAY H	SVIVE	1/1		06	tl7	8-	1-03	5
	3		30. Name and address of person v	11			•		- 51			
	/		J. Patri¢k Jarb				Notch Ro	ad, Hol	Lywood,	Maryla	ınd 206	36
	Sta Regist	ate	31. Date filed (Month, Pay, Year)	0 3 2005	Register's Signa	ature #	frede					
afr.	negist	खा	nou.		A PARTICION AND ADDRESS OF							

			1 - For State Registrar	State of Ma	aryland /	-	artment <i>tificate</i>			ınd Me		iene	005	26316		
	Physici /Medic		1. Decedent's Name (First, Middle, Last, TAMES D		ARD					2	Date of Deat		2 o cs	3. Time of Death		
	Examir		4a. Macility Name (If not institution, give Washington County	Hospital			Н	ager	Location of		/	4c. C	County of Deat Washir			
	Funeral Director		5. Social Security Number 6. Security Number 225-24-0287	7. Ag	e (In yrs. last b	virthday) Yrs.	If Under	Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, eb.4,19	Year)	9. Birt <i>C</i> o V i	nplace (State or Foreign untry) .rginia		
	the Maryland 28e-f show	tor	10a. State 10b. County Maryland Washing	gton	10c. City, To		cation kstow	n						10d. Inside City Limits 1X Yes 2 □ No		
	th with the 23a or 28d usi be not	al Director	10e. Street and Number 110 N. Antietam S	Street			10f. Zip	Code	2173	34	10	10g. Citizen of What Country? USA				
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28e-f show other treumatic event, the Medical Extination must be tradified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give Year or Dates:			Vas Decede f Yes, speci I ☐ Yes 2		spanic Orig , Mexican, Specify:	jin? (Speci , Puerto Rio	fy Yes or No- can, etc.)		4. Race - Ame Black, White Specify: W			
21215-0036	d within 72 ho plene. r than "natu the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5 2		(Give . life. L	lent's Usual kind of work DO NOT use recti	done di retired)	uning most			16b. Kind	ndustry prison			
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Ma	To Be C	17. Father's Name (First, Middle, Last) Melvin C. Ward		,						First, Middle, M Lee Din		iumame)			
	1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relationship (Ty Betty Ward - wife 20a. Method of Disposition	pe, Print)		10 N	. Ant	ieta	m St.		Route Number, nkstown	, Ma		21734		
Baltimore,	t. Page rtment o rtant: If		1			r La	ıwn Me	m. F	ark	7/30 MTNN		lager	rstown,	Maryland		
a a	Dermi Deper Impo any ir		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused ne cause on each lin	the death. Do	CK	5 E.	Wils	on B	lvd.,	Hagers	town		Approximate Interval Between		
,8760,	Physician / Medical Examiner in the purial-transit in the purial-t	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as	a consequence a consequence val v a consequence val a consequence	egu Va	ytimi, vgite eve	tio	4	P5 e				Onset and Death		
.O. Box 687	The law requires that the death certificate tee has been signed by the attending phy age 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 8 \(\text{Unknown} \)	3c. If yes, outcome 1	2 Fetal deat		Ectopic pre					23	d. Date of deli	very Day Year		
Δ.	w requires that been signed by should be deta	by	Part II. Other significant conditions con Alzheimers di		ut not resulting	in the un	iderlying cai	use giver	n in Part I.			acco use		the cause of death?		
Il Records,		Completed								_	24a. Was ar autopsy perform 1 Yes 2	,	prior to c death?	opsy findings available ompletion of cause of		
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	lospital: 1 ☐ Inpatie	ent 2 KERVO	utnationt	3 DOA	Other			Check only one		Other (Sage	16.1)		
ion of	ing After une	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	ry 28b.	Time of Injury		c. Injury a	at	280	d. Describe hor			·iy)		
Division	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined		et, factory,				City or Town,	State)		al Route Number,				
	To the Hosp within 24 hor To the Fune completely fi	edical	29a. Certifier 1 Certifying Physical Control (Check only one)	sician: To the best oner: On the basis of and manner sta	examination a	je, death nd/or inv	occurred at estigation, i	the time	, date and nion, death	place, and occurred	d due to the ca at the time, da	use(s) ar te and pl	nd manner as lace, and due	stated. to the cause(s)		
)	To the within To the comp	Me	29b. Signature and title of certifier	Levdor	in		29c.	License 45	number 563		29	Jul	signed (Month	Day, Year)		
H-	10+1		30. Name and address of person who con Radu M. THEODOR	mpleted cause of d	eath (Item 23a)	(Type, F	Print) Anti	etan	u stv	eet.	Haos	nst.	wa. Ms	oveland		
	Sta Registr		31. Date filed (Month Par Year) 2 20)05 32. Begistra	ar's Signature	4	eles)	11-3			2005 prylond		

			1 - For Stata Registrar	State of Ma		epartme <i>Certifica</i>			d Mental Hy	ygiene Reg. Ng. (0.05	26317
≅g-	P.D.		1. Decedent's Name (First, Middle, Last,)				<u>.</u>	2. Date of D	eath		3. Time of Death
	Physici /Medio		Lucille	E.	W:	illiam	S		July	17, Day	005 Year	7:25 PM
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. Cit	y, Town, or I	Location of De	eath	4c. C	ounty of Death	
			Magnolia Nursing				Green	belt		Pr	ince Ge	orge's
	Funeral		5. Social Security Number 6. Security Number	7. Age	(In yrs. last birtho	Month		if Under 24 H	lin. 8. Date of B	irth	9. Birthp Coun	lace (State or Foreign try)
	Director		577-40-2575 Usual Residence of Decedent		93 ''	·			March	8, 19		nston, SC
	yland Now		10a. State 10b. County		10c. City, Town o	r Location					11	0d. Inside City Limits
	a-f st	io	District of Col	lumbia		Wash	ingto	n				1 Yes 2 No
	or 28	Director	10e. Street and Number			10f. Z	ip Code			10g. Citize	on of What Coun	try?
	ath w	ra	4210 East Capitol	Street,	NE #20		2	0019		Unit	ed Stat	es
ယ္	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, it e Madical Examination at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give	ver in U.S.		edent of His ecify Cuban 2 1 No		(Specify Yes or Nierto Rican, etc.)		Black, White,	an Indian, otc African-
S	ural',	d b	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:		1 🗆 165	26 NO	Specily.		S	pecify: Am	erican
215-0036	n 72 t	Completed by	15. Decedent's Edu (Specify only highest grad	cation e completed)	1 (G	ecedent's Us live kind of w le. DO NOT	ork done du	ion iring most of i	working	16b. Kind	of Business/Ind	iustry
12	within ene.	шc	Elementary/Secondary (0-12)	College (1-4or 5+)			sekeep	er	Se	1f Empl	oved
ק ס	Hygie other ent, II	Be C	17. Father's Name (First, Middle, Last)						lame (First, Middle			oyeu
lan	should be and Mental marked o umatic eve	To B	John Edwards						e Etheri			
Maryland	and N	_	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. M	ailing Addres	s (Street an		Rural Route Numb		own, State, Zip	Code)
	s 1 and 2 should if Health and Men Item 27 is marke other traumatic		Henry W. Edwards -	Son	930	1 01d	Pa1me	r Rd.	Fort Wasl	ningto	n, MD 2	0744
Baltimore,	of He		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ R	emoval from State	20b. Place of Di cemetery, of	sposition (Na crematory or	ime of other place)	ı İ	Date	20c. Loca	tion - City or Tov	wn, State
Ē	perrit. Pages Dep riment of Important: If It any njury or o		`4 □Donation 5 □Other (Specify)	emovaritom State	Harmony	Memor	ial P	ark Ju	ly 23, 20	005 La	ndover.	MD
200	Depart Import any in		21. Signature of Fureral Servic Licens	Acon	.0	22. Name a	nd Address	of Facility	C		7 77	-
	40260		MO CI	mon	Man	4001 E	ennin	g Road	NE Wast	ningto	n, DC 2	0019
	Physician		23a. Part 1 3 ter the disease, if complishock, leart failure. List only or Immediate Cause (Final disease or condition	cations that caused the cause on each line.	Se OSIS		de ot dying,	such as card	iac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):	1 1						30045
	Examiner	_	Sequentially list conditions,		Decu	biti					7	burchs
_	be sit	iner	Tarry, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	7 dvanc	05	7000	tio				/ 6
•	xecut and al-trar	Examine	that initiated events resulting in death) Last	Due to (or as a o	consequence of):		berne.	<i>x</i> // <				1891
8/60	icate be executed physician and s the burial-transit	dicai		,	, , , , , , , , , , , , , , , , , , , ,							
200	g phy as the	edic		•			-					
X Q	law requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/Me	230. Tras decedent pregnant	3c. If yes, outcome of		0.05				23d	I. Date of deliver	y
	deat to atte	sicia	in the past 12 months?	1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown		3 □Ectopic p 5 □ Other (s					Month [Day Year
J.	at the	2hys	9 Unknown									
က်	res th signed be de	by	Part II. Other significant conditions con			Z Z Z	cause given	in Part I.				cause of death?
coras,	w require been si should b	eted	Gastroes	govia ge	eci (c -) 10 ×	01)	ease	10	Yes 2591	No 3□Proba	bły 4 ∐Unknown
a)	The law sate has t page 2 s	ompieted							24a. Was autoj	osy	prior to com	sy findings available pletion of cause of
	ician: The certificate harector, page	O.							1 Yes	2/2 No	death? 1 🗆 Yes 2	!□ No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:			Other		eath (Check only o			
ō	Phys r this eral di	-	1 Yes 2 No	28a. Date of Injury	2 ER/Outpat		28c. Injury a		Home 5 Resident			
0	ding f th. : After s funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	(ear) Injur		Work?	s 2 □No	Edd. Describe	now injury or	ccarred	
VISION	Atter r dea ector by the	Certification;	3 Suicide 6 Could not be	28e. Place of Injury building, etc. (- At home, farm,				28f. Location (Street and N	lumber or Rural	Route Number.
5	s afte	Cert	4 Homicide	building, etc. ((Specify)				City or Tox	vn, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier Certifying Phys	ician: To the best of ref: On the basis of earling and manner state	tamination and/or	ath occurred investigation	at the time, i, in my opin	date and place ion, death occ	ce, and due to the curred at the time,	cause(s) and date and pla	d manner as sta ace, and due to t	ted. he cause(s)
	ro th within Fo tha	Me	29b. Signature and title of certifier			29	c. License n	umber	T	29d. Date si	igned (Month, Di	ay, Year)
			D 54I				DE	3793	4	7/	20/0.	5
)	(5)		30. Name and address of person who cor	npleted cause of deat	th (Item 23a) (Typ	e, Print)			/	1 (-	
_	0		Stephanie Trifog				ay Cer	ter Dr	ive #430	Green	nbelt. M	D 20770
	Stat Registra	,c	31. Date filed (Month, Day, Year)	22. Registrar's								
	a14016116	1 6	1111 0 7 71117									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician 22, July 2005 10:50 A. Delores Mae White /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Mariner Health Care of Bethesda Bethesda If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2/21/44 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2004 61 Virginia Director 225-56-4128 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or itams 23a or 28a-f show Peges 1 and 2 should be filed within 72 hours after deeth with the Maryle nent of Health and Mantal Hygiene.
The first Health and Mantal Hygiene.
The marked other them "natural", or iteme 23e or 28e-f show ury or other treumatic event, The Maricel Examine man be notified at 1 ☑ Yes 2 ☐ No Washington D.C. Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20019 5626 Clay Place, N.E. U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22.No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, WAIFrican-1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: American Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Brown Carrie Childress 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # 25 Preston Ct., Villa Rica, Ga. Harry E. White/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: If any injury or once. 7/29/05 Harmony Mem. Park Landover, Md. ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility H.S.Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee any) late 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): **Examiner** Transverse Myelitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year jo 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 2 No 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Hospitel or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: Ai 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel I filled 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 22, 2005 D0057124 on D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, # 201, Rockville, Md. 20850 Truong Bao, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 7 2005 Registrar

			For State Registrar	State o	f Marylar	-			ealth a Death	and M	-	giene Reg. NG.	0.05	26319
	Physici /Medic		1. Decedent's Name (First, Middle, Johnnie Wilmore								2. Date of Dec		Year	3. Time of Death 4:50 pm _M
	Examir		4a. Facility Name (If not institution, 311 Zelma Ave.	give street and nu	mber)				Location o				county of Dea	eorges Co.
	Funeral Director		579-62-1535	5. Sex 1 M 2 □ F	7. Age (In yrs. 59	last birthday) Yrs.	If Undo	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 03-16-	y, Year)	1 0	rthplace (State or Foreign Jountry) shington DC
	Maryland I-f show fled at	tor	Usual Residence of Decedent 10a. State 10b. County MD Prince	Georges		ty, Town or Lo		its						10d. Inside City Limits 1 X Yes 2 □ No
	with the 3a or 28s	i Direc	10e. Street and Number 311 Zelma Ave.					ip Code 0743				10g. Citiz	en of What C	country?
980	be filed within 72 hours after death with the Maryland hat Hygiene. 5d other then "natural" or Heme 23a or 28a-f show event, the Medical Exactling must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Pivorced	Armed Fo	2 ₹ No ve X			edent of Hi ecify Cuba 2 No	ispanic Oric n, Mexican Specify:	gin? (Sp <i>e</i> , Puerto f	cify Yes or No Rican, etc.)	i	4. Race - Am Black, Wh Specify: B]	
Maryland 21215-0036	within 72 horiene. Then "nature"	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th		1-4or 5+)	16a. Dece (Give life.	kind of w DO NOT	ork done d use retired	during most ()		ng		of Business	s/Industry
/land 2	2 should be filed and Mental Hygi is marked other reumatic event, I	To Be C	17. Father's Name (First, Middle, La Johnnie Wilmore		-	1				r's Name Ley 1	(First, Middle,			
, Mary	nd 2 shallth and 27 is m		19a. Informant's Name/Relationshi Deborah Wilmore			er 60	43 B	ed Wo		l. Wa	Route Numbe	MD 2	20603	
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If Item any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of uneral Service Li	ecity)	A	1 2	natory or Ine B	other place pt. (Church	n 07 Stri	ate 7–23–05 .ckland	Che Fune	eral Se	SC ervices
	Pnysician /Medical		23a. Partr. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on o	each line. lio Pulm	th. Do not ent	ter the mo	de of dyin			Camp S		gs, MD	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. Hype	(or as a consec ertension (or as a consec	n quence of):		_						
8760,	cate be executed physiclen and the burial-transit	dicai Examiner	Cause. Eitler Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	insons (or as a consec nary Ar	quence of):		se .						
.O. Box 6	death certifi e attending I ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live 1	tcome of pregna pirth 2 Peta nant at time of cown	al death 3[ĴEctopic] Other (≴	oregnancy specify)				23	3d. Date of de Month	Plivery Day Year
rds, P	sign d be	by	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the u	nderlying	cause givi	en in Part I.		23e. Did to			to the cause of death? Probably 4 Unknown
Il Record	The law ete hes b page 2 sl	Completed									24a. Was autop perfo 1 Yes	an osy rmed? 20 No	prior to death?	utopsy findings available completion of cause of s 2 \(\) No
Vital	stcien: T certificat rector, pa	Be	25. Was case referred to medical examiner?	Honoitale				04			(Check only o			
of	ling Phys n. After this funeral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Xatural 5 Pending 2 Accident investiga	28a. Date (Mor		ER/Outpatier 28b. Time o Injury		28c. Injury World	/ at	2	ne 5 v Resid 8d. Describe f			ecify)
Division	tet or Attencrs efter death	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be led 28e. Place build	of Injury - At h ing, etc. (Speci	ome, farm, str	reet, facto	ry, office		2	8f. Location (8 City or Tox		I Number or F	Rural Route Number,
	To the Hospitel or Al within 24 hours efter or To the Funerel Direct completely filled in by	edical	(Check only 2 Medical E.	Physicien: To the xaminer: On the b and man	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	vestigatio	n, in my o	pinion, deal	d place, a th occurre	nd due to the ed at the time,	cause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)
	To To	Σ	29b. Signature and title of certifier	(111			2:	C. License						th, Day, Year)
,	400		30. m. d address of person w	ho completed cau	se of death (Iter	m 23a) (Type,	Print)	MD 2	1952			07-1	-9-05	
	Am		Larren Wade 106	Irving	St. sui	te 204	NW	Wash	ingto	n DC	20010			
	Sta Registr		31. Date filed (Month, Day, Year) U 2 7 2005	Secret.	Registrar's Signa	ature Consti	,							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Nan	ne (First, Mid	ldle, Last	')					Death	- 2	2. Date of De			3. Time	of Death
Physician		Ann				West						Month JULY	23	2005	12:	55 A
/Medical Examiner		4a. Facility Name	(If not instituti	ion, give	street and nu					4b. City, Town	, or Loca	ation of Death		nty of Death		
Examiner				_	ING HO					LAR	3 0		PRIN	CE GE	ORGES	
uneral	5	5. Social Security		6. Se	×		rs. last birthday	/) If Und	er 1 Year Days	If Under 24 Hours	Hrs. {	B. Date of Bir (Month, Da			hplace (State	or Fore
irector		811-60- Usual Residence		1[□M 2-F	85	Yrs.	Wionths	Days	Hours		July 9	1920	VĬŘ	GINIA	
23a or 28e-f show was be rediffed at ral Director	-	10a. State	10b. Count	ty	-	10c.	City, Town or L	_ocation							10d. Inside	•
School Berg	3	MD	PRINC	E GE	ORGE'S		SPRI	NGDAL	Æ						**	2 🗆 1
be notified	5	10e. Street end Nu	umber					10f. Z	ip Code				10g. Citizen	of What Co	untry?	
123 E 123	8	3108 Ba	arcroft	t Ro					207					S.A.		
tem 27 is marked other then "neturel", or items 23a or 28e-f show other treumstic event, the Modical Evandrier must be notified at To Be Completed by Funeral Director	2	11. Marital Status1 ☐ Never Mar3 ☒ Widowed			12. Was Dece Armed Fo 1 ☐ Yes If Yes, Gin Year or D	rces? 2. Z No	1 U,S. 13.			dispanic Origin an, Mexican, F Specify:	? (Spec uerto R	ify Yes or No ican, etc.)		Black, White	rican Indian, e, etc. Black	
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DHMH 16 Rev 6/95

			State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Death Certificate of Death Reg. No. 2005 26321
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Eyvonne C. Williams 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ten, No. Huls Prince 6 eages
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 1 Months Days Hours Min. 1 June 1 Security Number Security Numbe
	be filed within 72 hours after death with the Maryland stal Hygiene. id other than "natural", or Items 23a or 28a-f show event. The Modical Extending the modified at	rector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Prince George Temple Hills 1⊠Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	or death with tems 23a or	Funeral Director	4407 23rd PKWY # T 3 20748 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc.
21215-0036	72 hours afte natural', or I	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working
d 2121	filed within Hygiene. other than " ent, Ire M.	e Completed	Elementary/Secondary (0-12) College (1-4or 5+) Cook 1 2 th 17. Father's Name (First, Middle, Last) Cook 18. Mother's Name (First, Middle, Maiden Sumame)
Maryland	2 should be and Mental Is marked of aumatic even	To Be	Charlie Cooper Udilia Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
d)	l and shealth		Darnick L. Wimple son 4437 Douglas St.NE Washington DC 20005 20a. Method of Disposition 1 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		Varrens Chapel 7/28/05 Prospect Hill, NC 21. Signature of Funeral Service Licensee Snead Funeral Home & Cremation Service Snead Funeral Home & Cremation DC 20011
l line	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
8760,	ate be executed hysician and the burial-transit	icai Examiner	Sequentially list conditions, tays Learn Lamber III cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.
P.O. Box 68	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year 1 Yes 2 No 9 Unknown 1 Vertical death 1 Vertical death 2 Fetal death 2 Vertical death 3 Vertical death 2 Vertical death 2 Vertical death 3 Vertical death 2 Vertical death 3 Vertical death 2 Vertical death 3 Vertic
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α	The transparent	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
sion of Vital	Attending Physician: Tr death. actor: After this certificator, the funeral director, pa	ation: To Be	25. Was case referred to medical examinar? 12 Yes 2 No 13 DOA 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28. Date of Injury (Month, Day Year) 28. Date of Death 2 Cherc 4 Nursing Home 5 Residence 6 Other (Specify) 28. Date of Death 3 DOA 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Date of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one)
Division	To the Hospital or Attend within 24 hours after death To the Funeral Diractor: completely filled in by the	I Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
)	4		Jakahu Arch & Hoo55927 July 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvadar Sylvator, 3 ay Hoss ital Drive, Chourly, Many Jany
	Sta Registr		SALVADA SIVETU 3 AY HOLS THE Drive Choury May Indy 31. Date filed (Month, Day, Year) 32. Megistrar's Signature 32. Megistrar's Signature

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	Physici /Medic		Decedent's Name (First, Mide John	lle, Last)	Wil	liams						2. Date of De July July		2005 ^{ar}	3. Time of Death 12:05PMM		
	Examin		4a. Facility Name (If not instituti The Millennium	on, give st	reet and num Forest	ville				Location o	f Death			County of Deat Prince (
	Funeral Director		5. Social Security Number 578–18–3245	6. Sex	M 2□F	7. Age (In yrs.	<i>last birthday)</i> 85 Yrs.	If Under Months	1 Year Days	If Under a	Min.	Date of Bird (Month, Da	r, 192	20 Dan	hplace (State or Foreign untry) ville, VA		
	Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. Count MD Pri	,	eorges		y, Town or Lo								10d. Inside City Limits 1 ★Yes 2 No		
	with the h	Funeral Director	10e. Street and Number 6805 Keystone		bri			10f. Zip	Code 2074	7				zen of What Co			
9600	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Exemited must be notified at	by	11. Marital Status **E Never Married 2 Ma 3 Widowed 4 Divorce	rried d	Armed For 1 Yes If Yes, Give Year or Da	2 TN O		1 ☐ Yes 2	2 (kno	Specify:	gin? (Spec , Puerto Ri	ify Yes or No can, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black				
Baltimore, Maryland 21215-0036	d within 72 t giene. or than "nate	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 12th	nt's Educa est grade	ation completed) College (1-	-4or 5+)	16a. Dece (Give life. Labo	dent's Usua kind of wor DO NOT us PE	I Occupa rk done d se retired;	ition <i>luring</i> mosl)	of working	7	16b. Kind of Business/Industry Washington Post				
/land	12 should be filed within "h and Mental Hygiene. 7 Is marked other than "traumatic event, It a Men	To Be C	17. Father's Name (First, Middle Emanuel Wil			Anni						First, Middle, Will	Maiden . iams	Sumame)			
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imore	Page nent cant ant: If	8	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other		moval from S	State	Place of Dispo cemetery, crei OWard	natory or o	ther place		7/19			cation - City or Shingto			
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Eurera Service	License	A	7) 22	Austi 3821	n Ro	vster	Fune	eral Ho Wash	ome ingto	on. DC	20011		
	Physician		23a. Part1. Enter the disease, shock, or heart ailure. Li Immediate Cause Final disease or cond. n	or complications	cause on ea	nused the deat ach line.		er the mode	e of dying	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death		
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8760,	rate be executed whysician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liberse of the light that initiated events resulting in death) Last	c.	`	or as a consec	,							<u></u>			
O. Box 6	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	1 Live bi	come of pregni rth 2 Teta ant at time of c	al death 3	Ectopic pro			-		2	23d. Date of del Month	ivery Day Year		
٥	quires that n signed b uld be deta	by	Part II. Other significant condi	ions cont	ributing to de	ath but not res	sulting in the u	nderlying ca	ause give	on in Part I.			obacco u: Yes 2		the cause of death?		
Records,	The law requir ate has been si page 2 should	Completed					-		·			24a. Was autop perfo		24b. Were au prior to death?	topsy findings available completion of cause of		
Vital	sician: certific rector,	To Be C	25. Was case referred to medic examiner? 1 Yes 2 No		ospital:	npatient 2	FB/Outcation	nt 3 DO	Othe			Check only o	one)	i □Other (Spec			
o	ding h. After fune	ation; T	27. Manner of Death	ing tigation		of Injury h, Day Year)	28b. Time o Injury		8c. Injury Work		28	d. Describe			ony)		
Division	D ir	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Injury - State) 28b. Time of Injury - State -									iral Route Number,						
	To the Hospital within 24 hours a To the Funeral C completely filled	edicai	29a. Certifier 1 Check only 2 Medica	ing Physi I Examin	cian: To the er: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred vestigation.	at the tim	ie, date an pinion, dea	d place, an	d due to the at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)		
)	To t withi To t	29b. Signature and title of certifier D0055314 29c. License number D0055314 29d. Date signed (Month, Day, Year, Duly 22, 2005															
	4		30. Name and address of persons Sylvester Ok	onkwo				-	Road	Suit	te #5	07 0xn	n Hi	11, MD	20745		
į	Sta Registi		31. Date filed (Month, Pay, Yea		05 32.6	egistrar's Sign	ature	radio									

			1- For State Registrar		artment of Health and Natificate of Death		ne N2005	26323
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
1	Physici /Medi		John L. Walst	rum Sr.			Pay Year 3	8:02a M
	Examir		4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Sunbridge Care		E1kton		Ceci1	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	ar) Cou	nplace (State or Foreign untry)
	Director		220-32-2957 X M /	07		July 6,1	938 MD	
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
:	e Mar	ctor	MD Cecil	Elkton	1			1 ☐ Yes 2X No
3	15 th	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	untry?
:	death with the Maryland ims 23a or 28a-f show imst be nullied at		109 Milestone Ro		21921		U.S.A.	
	2 hours alter death with the Marylan atural; or Itams 23a or 28a-f show cal Examiner must be nutified at	Funeral	A	as Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
<u>ج</u>	hours atter tural', or Ita al Examine	by	1 Never Married 2 Married 11 3 Widowed 4 Divorced Y	Bai Ui Dales	1 ☐ Yes 2 ☐ No Specify:		Specify: Wh	ite
	2 hou	ted	15. Decedent's Education	1962 6a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	16b.	. Kind of Business/h	ndustry
7	within 72 ene. than nai	Completed	(Specify only highest grade com Elementary/Secondary (0-12)	ollege (1-4or 5+)	ning of work done during most of work DO NOT use retired)	ing		
N		S	12	_ Assem	bly Line Worke	r C	hrysler	Corp.
ב ו	tal H d of	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Maid	en Sumame)	
<u> </u>	should and Men s marks umatic	ဥ	Nelson James Wa 19a. Informant's Name/Relationship (Type, P.		Rhoda ng Address (Street and Number or Run	_Birney	v or Town Chate 7	in Code)
Z	t 7 2		Rose Walstrum/Wife		· ·		1000 E000E0	222
စ် .	Hear Hear		20a. Method of Disposition	20b. Place of Dispo	Milestone Rd.,		Location - City or T	921 Town, State
٥ آ			15☐ Burial 2 ☐ Cremation 3 ☐ Remov 15☐ Burial 2 ☐ Cremation 3 ☐ Remov	ai from State	Cemetery July	26,2005	Elkto	n MD
	그 문문 등		21. Signature of Funeral Service Licensee		2. Name and Address of Facility	20,2003	EIRCO	II, MD
ñ	Depa Impo any ir		Elwel Micheol	A	ndrew G. Gee F	uneral H	ome	
			23a. Part1. Enter the diseast, or complication shock, or heart failure. List only one cau	ns that ceused the death. Do not earlies on each line.	5.9 m. F. of Manual Chas State	resElkton	, MD 2	Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	Chamic Obstru	clive Pulmonare	Disense	,	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):	Care 1 act 11 a record	To rock the		VINZ O TOWN
,	Examiner	_	Sequentially list conditions, b					
1	ed Isit	Jine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
2	s be executed sician and burial-transit	Examiner	that initiated events c.	Due to (or as a consequence of):				
	cate be e) physician the buria	dical E	d					
9	certificate Iding phys Ise as the	ledi						
Š į	endin endin	Z/N	230. Was decedent pregnant	yes, outcome of pregnancy □Live birth 2 □ Fetel death 3 □	Ectopic pregnancy	10	23d. Date of deliv	,
. ;	res that the death certific igned by the attending p be detached for use as	Physiclan/Me	1 Yes 2 No		Other (specify)		Month	Day Year
ר ר	d by ti etach	Phy	9 🗆 Onknown			On Bidashaa		
13,	requires that the een signed by th hould be detache	þ	Part II. Other significant conditions contribut	ing to death but not resulting in the ur	nderlying cause given in Part I.	1 Tes	o use contribute to t 2 □ No 3 □ Pro	/
Hecords	w require been sign should t	etec	ti T	eus				
9	a & C/	ompleted	reper lense	n		24a. Was an autopsy performed/	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
_ F		မ Co	25. Was case referred to medical			1 Yes 2 1	No 1 ☐ Yes	2 No
5	rnysicien: Ine Ihis certificate ha ral director, page	o Be	examiner? 1 Yes 2 No	al: 1 ☐ Inpatient 2 ☐ ER/Outpatien		n (Check only one) me 5 ☐ Residence	6 DOther (Special	4.1
	g Frrys er this eral di	n:T	27. Manner of Death 28a	a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in		19)
0	Attending ir death. actor: After by the fune	atio	2 ☐ Accident investigation	(INORIT, Day 1 dar)	M 1 Yes 2 No			
DIVISION	iracto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	 Place of Injury - At home, farm, streething, etc. (Specify) 	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Run ate)	al Route Number,
ב ב	to the nospital or Attanding Fri within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral							
3	Fune Fune Fune	edical	(Check only 2 Medical Examiner: C	: To the best of my knowledge, death on the basis of examination and/or inv nd manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as s ind place, and due t	stated. o the cause(s)
4	ithin i	Mec	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month,	Day, Year)
)	- ≯ - ŏ		> Jackders	m	D0023272		7.26.0	5
	Rix.		30. Name and address of person who complet	ed cause of death (Item 23a) (Type	Print)			U.
	1/2		S. S Sciolides M.), 118 North 8	D0023322 Frint) Suite 3B, E-	Exten Mi	3 21921	
	Sta		31. Date filed (Month, Day, Year)	22. Registrar's Signature	Kı			
	Registr	rar	JUL 2 7 2005	Stow A A	Se.			

		For Stete Registrar	State of M	larylar				ealth a	and M	, ,	iene	005	26324	
Physici	an	1. Decedent's Name (First, Middle, La	williams							July 20		OOF Year	3. Time of Death	
/Media	cal	Leon 4a. Facility Name (If not institution, gi				4h Cih	Town or	Location of	of Death	July 20		County of Dea	11:22 P M	
Examir	ner	Garrett County N		-	a1		land	Location	n Death			rrett	un	
Funeral Director		219-14-5871	Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. 82	last birthday) Yrs.		Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 11/02/19			thplace (State or Foreig ountry) ry land	n
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
Mary a-f sh	to	MD Allega	ny		Cum	mberla	nd						1 ∑Yes 2 □ No)
th the or 28s	Olrec	10e. Street and Number				10f. Zi	p Code			1	l0g. Citi	zen of What C	ountry?	
ath w	ral	728 Gephart Dri					2150					USA		
DESILITIOTE, INTERTIGING Z.I.Z.I.3-UUJO permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Ptygene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show may injury or other traumatic event, I've Mardical Exa. illust: use the ricitified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes 2X If Yes, Give Year or Dates	?] No		Was Dece f Yes, spe 1 ☐ Yes		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify:		
2 hou	ted	15. Decedent's E (Specify only highest gi	Education		16a. Deced	lent's Usu	al Occupa	ation	t of worki	200	16b. Kii	nd of Business		_
ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT	use retired	turing mos)	OI WOIKI	ng .				
iled w Hygier Hher th		17. Father's Name (First, Middle, Las	t)		J	anito	r	19 Mothe	r'e Name	(First, Middle,		blic Sch	ools	
ryiand	To Be	Ernest	Wi	lliams	401-14-15		10:	Blar	iche	Loui	se		Edwards	
Mand Ith and 17 is r		19a. Informant's Name/Relationship Donna Dews / niece	(Type, Print)							<i>i Route Number</i> , New Yor	-		Zip Code)	
s 1 ar if Hear item 2		20a. Method of Disposition			Place of Dispo cemetery, crem	sition (Na	ime of	a)	С	ate	20c. Lo	cation - City or	Town, State	
DEMILITION Dermit. Pages Department of mportant: If it iny injury or o		1 ☐ Burial 2 XCremation 3 ('4 ☐ Donation 5 ☐ Other (Spec	_	9	mberland	-		· 1	07/23	2005	Cum	berland,	Maryland	
Dall permit. Departr Importe any inju		21. Signature / Fune Service Lice	see /		22					ms Family	Fun	eral Hom	e, P.A.	Π
		* Filet C	- all	u						Sumberland		ryland		
Pnysician /Medical		23a. Paff1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each a. acute m	_{line.} yocar	dial i				cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death 15 minute:	s
Examiner			Due to (or a			rdio		102 4	dicor	100			5 years	
ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Dua to (or a			Lulo	vasco	ital (1156	156			J years	
of ou, cate be executed bhysician and the burial-transit	al Exar	that initiated events resulting in death) Last	c. Due to (or a	s a conseq	uence of):									
OO/ rificate g phys	edical		d											_
I necolds, F.C. BOX of The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	I death 3	Ectopic p Other (s	oregnancy pecify)				2	23d. Date of de Month	livery Day Year	
uires that t signed by	by Ph	Part II. Other significant conditions								23e. Did to	bacco u	se contribute t	o the cause of death?	
law requires as been sign.	ted	diabetes mellitu	is type tw	o; se	nile o	nset	deme	ntia		1 🗆 Yı	es 2	XiNo 3□P	robably 4 Unknown	1
Vital neco sician: The law r certificete has be rector, page 2 sh	Completed									24a. Was a autops perform	sy	24b. Were a prior to death?	utopsy findings available completion of cause of	Э
VICAL sician: T certificet rector, pa	Be	25. Was case referred to medical examiner? 1 \sum Yes 2\hat{X} No	Hospital:			V.	OA Othe			(Check only on	-			
Phys	To To	27. Manner of Death	28a. Date of In	jury	ER/Outpatien 28b. Time of		OA 28c. Injury Work	7		ne 5 🗌 Reside			ecify)	-
Attending ar death. ector: Atte by the fune	atlor	1XXIatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	lay Year)	Injury	М		(? Yes 2 ☐ !				,		
al or Atte s efter dea of in by th	Certification:	3 Suicide 6 Could not determined	286. Place of I	njury - At h etc. (Specil	ome, farm, str	eet, facto	ry, office		1	28f. Location (Si City or Town			ural Route Number,	
To the Hospital or Attending Physician: within 24 hours efter death. To the Funerel Director: After this certifical completely illed in by the funeral director.	edical	29a. Certifying P (Check only one) Check only one)	hysicien: To the bes miner: On the basis and manners	of examina	owledge, death	occurred vestigation	at the tim	ie, date an pinion, dea	d place, a	and due to the c ed at the time, d	ause(s) late and	and manner a place, and du	s stated. e to the cause(s)	
To t To t	×	29b. Signature and title of certifier	57110	len	el		c. License					e signed (<i>Mon</i> . y 21, 2		
nds		30. Name and address of person who Walter K. Naumann	completed cause of	death (Iter	n 23a) (Type, 106 Ce	Print) mete	ry Ro	ad, A	Accid	lent MD	215	20		
Sta Regista		31. Date filed (Month, Day, Year) JUL 2 5 2005	32. Regis	trar's Signa	Sperke	1								

			1 - For State Registrar	State of M	laryland		artmen rtificate			and M	F	Reg. N2.	105	2632	5
П	Physici	an	Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	ath Day	Year	3. Time of De	
	/Media		Miriam	Evangeline		W	ebster			10 11	July 23,	2005		4:50 A	M
	Examin	er	4a. Facility Name (If not institution, giv				,		Location o	of Death			nty of Death		
	Euperel		Allegany County Nursi 5. Social Security Number 6.5		ge (In yrs. la	st birthday)	If Under	mberl 1 Year	and If Under	24 Hrs.	8. Date of Birt	h	Allegan	,	oreian
	Funeral Director			IDM 2DE	94	Yrs.	Months	Days	Hours	Min.	(Month, Day 08/23/1	910 910	New	pplace (State or Fountry) Jersey	,, o.g
	P .		Usual Residence of Decedent												
	show	2	10a. State 10b. County MD Alleg	ransr	10c. City,	Town or Lo	iberlan	А						10d. Inside City L	
	be M	ectc	10e, Street and Number	,any								10- 01	-(115- 1-0-		
	with with the second	급	412 North Centre	Street			10f. Zip	21.50	12			10g. Citizen	USA	untry :	
	Jeath	Funeral Director	11. Marital Status	12. Was Decedent	t Ever in U.S	i. 13. V	Was Deced			gin? (Spe	ecity Yes or No-		Race - Amer	rican Indian,	
မွ	or Ital	Ξ	1 ☐ Never Married 2 Married	Armed Forces	No					, Puerto	ecify Yes or No- Rican, etc.)		Black, White	e, etc.	
8	72 hours after death with the Maryland Insturel', or Itams 23a or 28a-f show Jical Excellent must be mailfied at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	:		1□Yes 2	210J No	Specify:			Spe	wh:	ite	
7	72 h "natu	Completed	15. Decedent's E (Specify only highest gr			16a. Deced (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition (u <i>ring m</i> os	t of work	ing	16b. Kind of	f Business/I	ndustry	
12	within ene. than	du	Elementary/Secondary (0-12)	College (1-4or	5+)		-Owner	ie retirea,	,			Deco	rating		
р 2	e filed within al Hygiene. I other than '	a l	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	First, Middle,				
lan	should be nd Mental marked o	To B	William	Finlaw	7				Juli	а			Mart	s	
Maryland 21215-0036	d 2 sho th and th sm 7 is m traum	1 78	19a. Informant's Name/Relationship (Robert C. Webster, J.								a <i>l R</i> oute Numbe Cumberlan				
	permit. Pages 1 and Department of Health Important: If Itam 27 any injury or other to		20a. Method of Disposition			ace of Dispo	sition (Nan	ne of	2)		Date	20c. Location	on - City or 1	Town, State	
Baltimore,	Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special		9	crest l	-			7/28/	2005	Cumber1	and, M	arvland	
alti	permit. Departri Importa any inju		21. Signature of Fu eral Service Lice	nsee							s Family			2	
<u> </u>	825 8 8	. X	Kihut (- Cu	lem	_	404 De	ecatu	r Stre	et, C	umberland	, Maryl	and 2	1502	
	Physician /Medical Examiner		23a. Par1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Conq	tine.	0	Hear Hear New	jaying	cui	luv.	or respiratory ar	rest,		Approximate Interval Betwee Onset and Dea	th
8760,	icate be executed physician and s the burial-transit	dicai Examiner	Secuentially let conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Seven	s a con wheel	wite	ger	uà	۴						
P.O. Box 6	The law requires that the death certific tie has been signed by the attending p cage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal of	death 3□	Ectopic pr Other (sp						Date of deliment	very Day Yea	r
	res tha	by P	Part II. Other significant conditions	contributing to death	but not resul	iting in the u	nderlying	\			23e. Did to	bacco use c	ontribute to	the cause of deat	h?
Records,	w require been si should b	ted	La fecon mite	> Curtic	_ Ste	180m	5 1	rep	1888	The	1 D Y	es 2 No	3 □ Pro	obably 4 Unk	nown
ecc	elawr hasbe je 2 sh	Completed	S/P (n-1.)	weedi'v	~q,≤	serre	val	-lil	born		24a. Was autop	sv	prior to c	topsy findings ava completion of caus	ilable e of
_		S		MS.					'			med? 2∭No	death?	2□ No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	AF		n (Check only o				
of	Attanding Physician: r death. ector: After this certification of the funeral director.	1. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpat 28a. Date of Inj (Month, Di		R/Outpatien 28b. Time of		8c. Injury Work	4 NI NU	-	me 5 Resid			cify)	_
lon	nding I th. : After e funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year)	Injury	M		:? ∕es 2 🔲	No					
Division	for Attai after des Director in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Ir	njury - At hon etc. (Specify)	ne, farm, str	eet, factory	, office			28f. Location (S City or Tow		ım <i>ber</i> o <i>r Ru</i>	ral Route Number	r
	To the Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exa	hysician: To the bes miner: On the basis and manner s	of examination	rledge, death on and/or in	n occurred vestigation,	at the tim in my op	e, date an pinion, dea	d place, th occur	and due to the cred at the time,	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)	
		M	29b. Signature and title of gertifier	Le			2	License		770		29d. Date sig			
	2		V. A. Kany	il han			1	19	75	0		While	26,0	2000	
t	DB		30. Name and address of persol												
	かん		Vimala A. Ra	· · · · · · · · · · · · · · · · · · ·	trar's Signatu		wn Road	d, Cur	nberla	nd, M	ary land	21502			
	Sta Registi		JUL 2 6 2005		, Jan a Signati	Spare	W								

			For State Registrar		State of M	arylan				lealth ai Death	nd Me	ntal Hy	giene	005	26326	5
	Dhyaisi		1. Decedent's Name (First, Mic	ddle, Last)							2.	Date of De	eath Day	Year	3. Time of Deat	
	Physici /Medi		Zelda		Ruth		Wa	oner			7	viu	al	200	5 8:15 -	AM.
	Examir		4a. Facility Name (If not institu	tion, give :	street and number,)		4b. City,	Town, or	Location of	Death		4c.	County of De	ath	
	Funeral		Memorial 5. Social Security Number	1-105 6. Ser		ge (In yrs.	last birthday)	If Under Months		If Under 24	4 Hrs. 8.	Date of Bi	rth ay, Year)	A Nec	thplece (State or For	eign
	Director		220-16-6989	- '-]M 2√7 F	86	Yrs.		,-		(05/01/1	919		yland	
	Du 🖈		Usual Residence of Decedent 10a, State 10b, Cour			10a Cit	y, Town or Lo	nation							40d Incide Circuit	-14
	72 hours after deeth with the Maryland natural', or Items 23a or 28a-1 show dical Examinar must be redified at	_	MD 100. Coul	-	~0****	100.01	•	berlar							10d. Inside City Lir 1 ☑ Yes 2 ☐	
	Ba-f	Funeral Director		Alle			CUI									
	or 2	Oire	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of What C	Country?	
	23a	ie	109 Jac	kson S	Street				2	1502			U	SA		
	sme	ner	11. Marital Status		12. Was Decedent Armed Forces		.S. 13.	Was Dece	dent of Hi	ispanic Origi n, Mexican,	n? (Specif	y Yes or No	0-	14. Race - Am Black, Wh		
ဖွ	or It	F	1 Never Married 2 N	arried	1 ☐ Yes 2 ☒ If Yes, Give			1 ☐ Yes		Specify:	1 00110 1110	A11, 010.7			ite, etc.	
8	ours	1 by	3 🕅 Widowed 4 □ Divord	ed	Year or Dates:			103	290 140	Specify.				Specify:	White	
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21		nple	Elementary/Secondary (0-12		College (1-4or	5+)	life.	DO NOT u	se retired)	-:g					
	er er er	Son	7				He	omemak	er				I	lomemake:	r	
pu	al Hy al Hy Vent	Be (17. Father's Name (First, Midd	le, Last)						18. Mother	s Name (F	irst, Middle	, Maiden	Sumame)		
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Maryland	sho and h	Ċ	19a. Informant's Name/Relation	nship (Ty	rpe, Print)		19b. Mailir	ng Address	(Street a	and Number	or Rural F	Route Numb	er, City o	Town, State,	Zip Code)	103
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Depertment of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other treumatic event, it Medical Eventment he rotified at once.		20a. Method of Disposition				Place of Dispo	sition (Nai	me of		Date			cation - City o		
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<u>a</u>	that the by detact	F.	Part II. Other significant cond	itions cor	ntributing to death	hut not res	ulting in the u	nderlying c	ause dive	an in Part I		23e. Did	tobacco u	se contribute	to the cause of death'	?
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	To the Hospitel or Attent within 24 hours efter death To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifier (Check only 2 Medic	ying Phys	sician: To the best	of my kno	wledge, death	occurred	at the tim	ne, date and	place, and	due to the	cause(s)	and manner a	is stated.	
	he H in 24 he F plete	edi	one)		and manner s	lated.	tion and/or in	restigation	i, iii iiiy o;	omion, death		at the time,	uate and	place, and du	ie to tue canza(z)	
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	3			1-1	~				M	D33	280		7.	11. 2	7 2005	
			30. Name and address of per	on who co	impleted cause of	death (iten	n 23a) (Type,	Print)	er ene		-,00			3	5,5-3	
	nds		Sunil Kil	fque	ia 62	5 K	ent 1	Aven	ve	Sui	te 10	31 C	dme	erlan	d, Maryla	ba
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No 2005 Certificate of Death 3 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JULY 26 **Physician** 3:50AM ARTHUR AUGUST YIENGER SR. 2005 S /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year

100 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 70 5, Director 219-30-6607 DEC. MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23s or 28a-f show 1 ☐ Yes 2 X No Director MARYLAND WORCESTER BISHOPVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12211 GOOSE LANE 21813 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status If Item 27 is marked other then "naturel", or Item or other treumatic event, the Madical Examinat Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 Is marked other then "naturel", or Ite. Vienger 0 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Be Completed by WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC AUTO 12 アセンド 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) } ARTHUR YIENGER MARIE HITTEL 5 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) I Co Health a CAROL ANN YIENGER/WIFE 12211 GOOSE LANE, BISHOPVILLE, MARYLAND 21813 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department o Importent: If eny injury or once. CREMATORY OF DELMARVA 7/27/05 * 4 ☐ Donation 5 ☐ Other (Specify) DELMAR, DELAWARE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility elice HUT HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 CA 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardinagopally Pnysician Ischemic /Medical Due to (or as a consequence of): **Examiner** Recommendence Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner sician and burial-transit Due to (or as a consequence of): attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 7/26/0 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After and Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Marya HU053714 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey W 31. Date filed (Month, Day, Year) 394 FRANKIN Ne Suk 312 BERLIN MO 21811 matzoni O.O. 32. Pigistrar's Signature JUL 2 7 2005 Registrar Goarle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State AMEND23a(a/b/c)perMD7/27/05,DPS,McCoCertificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** HENRY ZIMON 2005 ULY 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Rocky111e

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. 06/10/1920 Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**∑**M 2□F 178-14-0023 85 Yrs. Director New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exactly or other traumatic event, the Medical Exactly or other traumatic event, the Medical Exactly or other traumatic event, the Medical Exactly or other traumatics. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2□No Directo Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 United States 259 Congressional Lane Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No WWII IFYes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Lipinska Andrew Zimon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 259 Congressional Lane, Rockville, MD 20852 Grace Zimon/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State Ft. Lincoln Crematory 07/26/2005 Brentwood, MD 4 ☐ Donation 4 5 ☐ Other (Specify) 21. Signature of I 22. Name and Address of Facility Simple Tribute Funeral and Creneral Seville License mation Center, 1040 Rockville Pike, Rockville, MD 23a. Part1. Enter the disease, or complications that vaused the death. Do not after the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Failure Aspiration_Pneumonia minute 1 day disease or condition resulting in death) Respiratory /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of) the attending physician Certification; To Be Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day jo in the past 12 months? 5 Other (specify) I ☐ Yes 2 ☐ No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 2**X** No peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 21**X**No certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day 1 Natural 2 Accident 5 Pendina 1 🗌 Yes after death. investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physicien: To the Hospitel or Attending within 24 hours a To the Funerel I completely

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

DWLIMI

29b. Signature and title of certifier

aduarn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

9901 NADKARNI gistrar's Signature MULLI

MEDICAL DRIVE GAITHERSBURG, MD

29c. License number

29d. Date signed (Month, Day, Year)

	1	For State Registrar	State of Maryland /		ment of He ficate of D		ental Hygie	ene ^{J. No.} O. O	00	0.000		
Physicia	ın	Decedent's Name (First, Middle, Last) Constance Louise	Adeyeri				2. Date of Death Month 08	05 ^y 20	05"	3 Time of Gears		
/Medica Examine		la. Facility Name (If not institution, give s 6708 W. Mooreland		4	b. City, Town, or Takoma	Location of Death Park		4c. County Mon	of Death tgome	ery		
Funeral Director		5. Social Security Number 6. Sex 1070-34-8157	7. Age (In yrs. last 63		f Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 107-26-1	942	Count	ace (State or Foreigr ry) Vork		
72 hours after death with the Maryland natural; or Items 23a or 28a-f show dical Examilner must be notified at		Usual Residence of Decedent		own or Locat					10	od. Inside City Limits		
3a or 284	Il Director	10e. Street and Number 6708 W. Mooreland	d Ave		10f. Zip Code	20912	10	g. Citizen of V USA	Vhat Count	ry?		
permit. Pages 1 and 2 should be filed within 72 hours after dealn with the warylar long the manaylar long structure of Health and Mental Hygiene. Importment if them 27 is marked other than "natural", or flems 23s or 28s-1 show any injury or other traumatic event, the Madical Ext. Injury or other traumatic event, the Madical Ext. Injury must be nutified at once.	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Noivorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∳∏No If Yes, Give Year or Dates:		s Decedent of Hises, specify Cubar	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America k, White, e			
ane. than "natura ne Mad cal E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give kin life. DO	nt's Usual Occupa nd of work done d NOT use retired; L Worker	uring most of work	ing	_		^{ustry} Hospital		
ental Hygic	Be	17. Father's Name (First, Middle, Last) William Kristoff				18. Mother's Name	(First, Middle, M Hormann	aiden Sumam	10)			
Ith and Me	ပ္	19a. Informant's Name/Relationship (Ty		19b. Mailing . 430 [Address (Street a	nd Number or Run ff Ave Ed	al Route Number, Igewater	City or Town, NJ 070	State, Zip	Code)		
nent of Heal int: If Hem 2 iry or other	1	Ayodele Adeyeri (son) 20a. Method of Disposition 1 Burial 2 Removal from State 4 Donation 5 Other (Specify) 430 Undercliff Ave Edgewater NJ 07020 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory 08-10-2005 Beltsvil										
Departr Imports eny inju		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complete	varm	Ra 9:	app Fune 33 Gist	ral & Cre Ave Silve	r Spring	MD 20	910			
Cate be executed Cate be exec	disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Acute Leukemic Due to (or as a consequence of): Due to (or as a consequence of):											
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this certificate	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatient	3□ DOA Oth	ar.	th (Check only one		or (Cassit	-		
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To the Hospital or within 24 hours after To the Funeral Director Completely filled in D	Medical (29a. Certifier (Check only one) 1 1 "Certifying Phy 2 □ Medical Exam	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	and due to the ca rred at the time, da	use(s) and mate and place,	anner as si and due to	tated. the cause(s)		
To the Within To the Comp	Me	29b. Signature and title of certifier	moid M	7	29c. Licens	e number	9 8	od. Date signe	ed (Month,	Day, Year)		
5		30. Name and address of person who saul Yavovich,		Mary la	rint)	ectical c	center,	Rell	timo	ne MI		
Sta Registr		31. Date filed (Month, DAUG") 1 2	32. Registrar's Signatur	re K	haut i					,		

			- FOI	epartment of Health and Mental Hygiene Certificate of Death Reg. NO. 0 15 26331
			Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physici		Irvin G. Adamson	July 25, 2005 9:30 A
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
			Future Care Homewood	Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min. (Month, Day, Year) Country)
	Director		133-52-2260 15M 2 1 78 Yr Usual Residence of Decedent	Jan. 25, 1927 Jamaica
	land ow		10a. State 10b. County 10c. City, Town of	or Location 10d. Inside City Limits
	Mary fish	ţo	Maryland Harford Bel Air	1 ☐ Yes 2 🗓 No
	r 28e	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	th wit		1106 Thebes Drive	21015 U.S.A.
	r dea	Funeral	Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	d within 72 hours after death with the Maryland jiene. r then "neturel", or ftems 23e or 28e-f show the Medical Exercit with matter notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 █ No Specify: Specify: Black
Ö	hour turel			ecedent's Usual Occupation 16b. Kind of Business/Industry
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212	d within giene. ir then "	mo;	Elementary/Secondary (0-12) College (1-4or 5+)	Vault Attendant (Unknown)
b	be filed v stal Hygie od other t	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
yla		2	David Samuel Adamson	Robertha Roe
Maryland 21215-0036	2 2 2			Aailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	s 1 and 2 f Health item 27 l			6 Thebes Dr., Bel Air, MD 21015 Date 20c. Location - City or Town, State
JOL	ages nt of I t: If its		1 X Burial 2 Cremation 3 Removal from State	crematory or other place)
Baltimore,	permit. Pages Department of I Importent: If ite any injury or of		' 4 □ Donation 5 □ Other (Specify) Plain □ 21. Signard of Funeral Service Licepses	Lawn Cemetery 8/2/2005 Hicksville, NY 22. Name and Address of Facility
Ba	Depar Depar Impor any ir		Danis Gettman	Tyler Funeral Home 201-20 Linden Blvd., St. Albans, NY 11412
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	
E	Physician		Immediate Cause (Final disease or condition	nte Endievanden Dokan Onset and Death
	/Medical		resulting in death) a Due to (or as a consequence of	
	Examiner	L	Secuentially list conditions b. Amal FX	nllatin
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89	ificate g physi as the l	ledic		
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy
	tt the deal by the att	sici	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	S Cther (specify) Month Day Year
P.0	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ds,	signe d be o	d by	Pendent Variler Discure	8 later pert 1 Yes 2 No 3 Frobably 4 Unknown
COL	w require been sign	ete	Prolet believe knee	comparter 24a. Was an 24b. Were autopsy findings available
Records,	The lav	Completed	Stall Paris I	autopsy prior to completion of cause of death?
Vital		a l	25. Was case referred to medical	1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)
>	S S	To B	examiner? 1 Yes 2X No Hospital: 1 Inpatient 2 ER/Outp	Other V
Jo L			27. Manner of Death 1. Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) Inj	ne of 28c. Injury at 28d. Describe how injury occurred
Siol	thendir death. ctor: Al y the fu	catle	2 Accident investigation	M 1 Yes 2 No
Division	l or Attendate after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of Injury - At home, fam building, etc. (Specify)	n. street, factory, office 28f. Location (Street and Number or Rural Route Number. City or Town, State)
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune		29a. Certifier 12 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/one)	or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	ro the	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
			> person M	D D31464 7/27(05
			30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print) Source Co to 200 Rolling MD
		27		(N. EUTAN ST Smte 30B, Baltmore MD 21201
	Sta Regist		31. Date filed (Month, Day, Year) 22. Registrar's Signature	ale ale

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** BANKI MAZIE 2005 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE COUNT MANOR CARE BALTINORE, MARYLAND POIAND PARK If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Dey, Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 90 1 M 2 F 219-07-5913 Director 03 23 VA Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☑Yes 2 ☐ No BALTIMORE, MD 13ALTI MORE Director 10g. Citizen of What Country? 10e. Street and Number Peges 1 and 2 should be filed within 72 hours after death with t and of Health and Mental Hygiene. and if item 27 is marked other than "natural", or items 23a or 2 ury or other traumatic event, the Madical Exculter mark to n TATES UNITED 201 N. WASHINGTON AVE. APT. TOS 71231 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 13 CC 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Private Duty 4th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jennie Macklin James Edward Banks 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2419 Madison Ave, Baltimore, Md 21217 Michelle Whitfield-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition ts Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Department of Important: If eny injury or once. Arbutus Memorial 8/13/05 Arbutus, Md 21. Sanature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md por 21215 Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Dechno Pr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consect ence of): Physician/Medical Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 4 Unknown Jomt Dicea 3 🗍 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 2 No 2 🗆 No 1 ☐ Yes 1 Yes or Attending Physician: ector, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA ₽ 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by 4 Homicide Hospital 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/8/05 D 31464 duta 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore A. HASHMIMD, 821 N. EUTAN ST frute 30f 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			. 101	partment of Health and Mertificate of Death		giene	26332
			Decedent's Name (First, Middle, Last)		2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		Frederick T. Bohlen		Aug	9 2005 year	5:42p
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
			Heritage Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Baltimore Baltimore Baltimore Baltimore		Baltimo	
L	Funeral Director		5. Social Security Number 6. Sex 120 M 2 F 7. Age (In yrs. last birthda 2 F 66 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth April	2 ⁶ , 1939 MZ	nplace (State or Foreign Cryland
	and		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Mary Fied	to	MD Baltimore Bal	timore			1 ☐ Yes 2X No
	r 288	by Funeral Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	untry?
	th will	aiD	1120 Northpoint Road	21222	1	USA	
	r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
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Ş	hour	ed b		cedent's Usual Occupation		16b. Kind of Business/l	
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yla	should be filed within 72 hours atter death with the Maryland nod Mentle Hyglene. Indexted other than "natural", or Itams 23a or 28a-f show imatic avant, the Medical Examiner must be notified at	은	Wilbur Bohlen	Iren B			
Maryland	d2st thanc thanc traun			illing Address <i>(Street and Number or Rura</i> 120 Northpoint 1			ip Code)
ē,	Heal Heal tam 2		20a Method of Disposition 20b. Place of Dis	position (Name of	Date	20c. Location - City or	Fown, State
E O	Pages ient of int: If i		1 Burial 2 Octobriation 3 Bemoval from State	rematory or other place) ewCrematory 8/1	2/05	Baltimore	e MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens				meofEssex
			23a. Part1. Enter the disease, or complications that caused the dead. Do not	300 Mace Ave. enter the mode of dying, such as cardiac of	Balti or respiratory arr	more MD 2	Approximate
.8.	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final CERE BRO —) disease or condition	JASCULAR A	+CCI F	SENIT	Interval Between
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	41/2000117	7141	10/11/103	
	Examiner		Sequentially list conditions b.				
7	p ====	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying				
V	and t-trans	xam	Cause (Disease or injury that initiated events resulting in death) Last C				
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687	iticate g phys	ed	d				
Вох	eath certitic attending p	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very
œ.	death	sicia	1 Yes 2 No	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
P.0	res that the designed by the a	Physician/M	9 🗀 Unknown				
JS,	Attending Physician: The law requires that the death certificate be executed redeath, redeath, archestly, actor: Attent this certificate has been signed by the attending physician and actor; the tuneral director, page 2 should be detached for use as the burial-transit	þ	Part II, Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to ies 2 No 3 □ Pro	the cause of death?
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Records,	has law	Completed	DIMSELES MELLE	103	24a. Was a autops perfor	sy prior to c	opsy findings available ompletion of cause of
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	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: Alter th completely filled in by the tuneral	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	ed at the time, d	late and place, and due	to the cause(s)
	To th within To th comp	Me	29b. Signature and tille of certifier	29c. Lidense pumber.		9d. Date signed (Month	, Day, Year)
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8	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	TOKE, MAR	7 LA	ND 2	(225)
	Registr		AUG 1 2 2005 General &	evil.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#23aPII perME C846 8/11/05 TT
State of Maryland / Department of Health and Mental Hygiene 26333 1 - State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** 5:10 PM 06 9 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD GOOD SAMARITAN BALTIMORE BALT IMORE JAT I 920 H If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days 1□M 2**X**F Hours 15-46-9601 Usual Residence of Deceder Director the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ es 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11. Marital Status be filed within 72 hours after de Itat Hygiene. Id other than "natural", or Item Armed Forces?

Yes 2 640

Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Secondary (0-12) College (1-4or 5+) 501 permit. Pages 1 and 2 should be file. Department of Health and Mental Hyg Important: if tiem 27 is marked other any injury or other traum-". er's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ္က 10 NNINGS 19b. Mailing Address (Street and Number or Rur Route Number, City or Town, State, Zip Code) BaltoMD 21234 Ld: Bolto Mi 20c. Cation - City or Town, State 20a. Method of Disposition 1 Nurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee seral Services w. que 2d. Ba 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Brain Ano xic disease or condition resulting in death) /Medical Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit certificate be executed Per forated Discus Due to (ordas a consequence of) Physician/Medical Strangulated Incisional Hernia with per foration IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ed bluods Status post incarcerated 1 Yes 2 No 3 Probably 4 Unknown tailure peeu 24a. Was an autopsy performed 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No hernia repair page 2 this certificate has 1 Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 Inpatient 1 X Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural Injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a To the Funeral I 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D 2005 RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LNGORANI BALTIMORE MD 21239 5601 LOCH RAUEN BLUD. 32. pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2 2005

Amend item#23, permb, 3846.8/12/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** CATHERINE BLICKENSTAFF AUGUST 05, 2005 6:28 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1-28-29 Birthplace (State or Foreign Country) **Funeral** Months 1□M 2XF Yrs 210-18-9420 **Director** PANSU Vanio Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Interest if item 27 is marked other than "patural", or items 23s or 28s-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 No М Completed by Funeral Director RFORI Hiv 20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 249 21015 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 □ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 nspec TOK other traumatic ayant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKnown 2 mma ring 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 423 man 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department of Important: If any injury or once. Hagerstown Cenoter. 8 *4 Donation 5 Dother (Specify) 10 21. Signature of Funeral Service License 22. Name and Address of Facility REST HIL 3 NEW PORT DR 1 lon EVANS FUNERAL CHAPEL or complications that caused the de t only one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Findisease or condition resulting in death) uremia Pmysician /Medical Due to (or as a consequence of) **Examiner** renal failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Box 68760. by Physician/Medical as the t IF FEMALE: If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy Į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 1 ☐ Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide lilled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie To the Funs completely f Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 32255 AUGUST D, 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR, MD. 31. Date filed (Month, Day, Year) 32. Begistrar's Signature 2 2005 1 Registrar

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permit. Pages 1 and 3 Department of Health Important: If Item 27	any injury once.		21. Signature of Funeral Service Licensee 22. Name and Aldress of Facility BALTI MORE, MD 212:										
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Physic	niao :		shock, or heart failure. Vist only Immediate Cause (Final disease or condition	one dause on each line.	mia	,		Interval Between Onset and Death					
/Med Exam	lical		resulting in death)	aDue to (or as a conseque				1 North					
LAGIII		-e	Sequentially list conditions,	b	ence of):			J. William					
cuted	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<u> </u>									
be execut	burial-translt	al Exa	resulting in death) Last	Due to (or as a conseque	ence of):								
tificate b	s the b			. d									
death certificate	for use as the l	In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan			23d. Date of de	alivery					
	should be detached for	Completed by Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of dea			Month	Day Year					
The faw requires that the d	detac	Phy	Part II. Other significant conditions c	ontributing to death but not resul	ting in the underlying cause given in P	Part I. 23e. Did t	obacco use contribute t	to the cause of death?					
quires on sign	ed blu	ed by	Chronic Obstru	ictive Valmo	nary Disease	10	Yes 2□No 3×3	robably 4 Unknown					
The taw requires to the has been signer	2 sho	piet	Diabeter Mel	litus		24a. Was	an 24b. Were a	utopsy findings available completion of cause of					
	, page 2					perfo 1 □ Yes	rmed? death?	s 2 No					
Physician: Th	funeral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Phopatient 2 ☐ E	Other	Place of Death (Check only of							
g Phy ter this	neral d	n: To	27. Manner of Death	Nursing Home 5 Resid	now injury occurred	ecify)							
i or Attending after death. Director: After	the fur	catlo	17 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	2 🗆 No									
i or Atl after d	in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (5 City or Tov	Street and Number or R vn, State)	lural Route Number,					
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte	tely filled	Medical C	29a. Certifier (Check only one) 2 Medical Example (Check only one)	niner: On the basis of examination	rledge, death occurred at the time, dat on and/or investigation, in my opinion,	e and place, and due to the death occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)					
o the vithin of	ендшо	Mec	29b. Signatur and title of certifier	and manner stated.	29c. License numl	ber	29d. Date signed (Mon	th, Day, Year)					
- s - \	5		* Janiel 6	uguin.	AV417642	5L16762	A1168.7	2005					
11			30 Name and address of person who	completed caus death (Item :	23a) (Type, Print)	03, Baltimore	ALD = 1==1						
7	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ombard St. Apt#20	15, Carol Harry	My 21201						
0.	-inte		ALIC 1 0 2/	205									

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma	aryland / Depa	artment rtificate			nd M		giene 0	05	26336
	Physicia		1. Decedent's Name (First, Middle, Las	BALCA	9 / A		-			2. Date of Dea Month	Day	Year 05	3. Time of Death 5. 45 P M
	/Medic Examin		4a. Facility Name (If not institution, give Future Care Nursing I	street and number)	1 44.7		Town, or	Location of			4c. Cour	nty of Deati	
	Funeral Director		215-01-1372		e (In yrs. last birthday) 83 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Aug. 22,	1921	Co	nplace (State or Foreign untry)
	show	70	Usual Residence of Decedent 10a. State 10b. County Md. N/A		10c. City, Town or Lo								10d. Inside City Limits N Yes 2 □ No
	or death with the Marylar tems 23a or 28a-f show at must be notified at	Direct	10e. Street and Number 1 West Conway St.			10f. Zip	Code 21201	l			10g. Citizen o	of Whal Co	untry?
920	ours after	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent If Armed Forces? 1 Yes If Yes, Give Year or Dates:	10		ent of Hi	spanic Orig	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14. R	ace - Ame lack, White city: Wh	
Maryland 21215-0036	within 72 ane. then "nai	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 8 yrs,	ucation de <i>completed)</i> College (1-4or 5	(Give	dent's Usua kind of won DO NOT us USEWITE	k done d e retired,	turina most	of working	ng	16b. Kind of		Industry
/land	should be filed and Mental Hygie marked other umatic event, the	To Be C	17. Father's Name (First, Middle, Last) Vincenzo Nash							(First, Middle,	Maiden Sum	ame)	
	1 and 2 sho Health and I tem 27 is ma		19a. Informant's Name/Relationship (Daughter	270	6 Tilde	n Rd.			Route Number	-	vn, State, 2	Tip Code)
Baltimore,	Page nent o ent: If ury or		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification 2)		20b. Place of Disponent Paltimore	matory or ot	ther place	n. <i>I</i>	lug. 1 200	5 ,)5	20c. Locatio		Town, State
Balt	permit. Page Department o Importent: If any injury or once.		21. Signature of Fungral Service Licer	Ly	G 7	2. Name and bnnelly 110 Sol	d Addres 7 Fund 1 lers	s of Facility Tal Ho Point	me Of Rd. 2	Dundalk 1222			
	Physician //Medical Examiner	al Examiner	23a. Part. Infer the disease, or com shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as			inc	W	^	MAM	_		Approximate Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	□Ectopic pre						Date of del	ivery Day Year
s, P	signed by	ρ	Part II. Other significant conditions of			inderlying ca				23e. Did to	12		the cause of death?
Record		Completed	Pruna	Bourne,	NI					24a. Was autop	an 24 sy rmed?	b. Were au	topsy findings available completion of cause of
Vital	Physicien: The this certificate har all director, page	To Be (25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	nt 3□ DO	A Othe	\P		ne 5 Resid		Other (Spe	cifv)
ion of	ding Ph h. Atter th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da			8c. Injury Work		2	28d. Describe h			
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the fune	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injuding, et	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory	, office		2	28f. Location (S City or Tow		mber or Ru	iral Route Number,
	ne Hospit n 24 hour ne Funer	Medical			of my knowledge, dea f examination and/or in ated.								
	To the To the Comp	M	29b. Signature and title of certifier.				0	number 242	16		29d. Date sig	10	
	5		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type 8 6 i H.J ar's Signature	Print)		St.	73	BACTIMO	OCE, N	,0,	21214
•	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 2 2	005 32. Sgistr	ar's Signature	book	,						1

			1 - For State Registrar	State of Maryla		artment of rtificate o			ene . <u>~2</u> 0 0 5	26337
	Physici /Medio		1. Decedent's Name (First, Middle, Las	EN F.	BOARD		SR.	2. Date of Death Month AUSIVST	Day 2005	3. Time of Death - 10:40 P M
	Examin	er	4a. Facility Name (If not institution, give AUCE MANO)	R		BAR	or Location of Dea	,	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Security Number 11 Sec	PX 7. Age (In y)	rs. last birthday) Yrs.	If Under 1 Yea Months Day			(ear) 9. Bir	thplace (State or Foreign ountry) ARYLAND
	Maryland -f ehow	tor	10a. State 10b. County	10c.	City, Town or Lo	cation	•			10d. Inside €ity Limits 1 Yes 2 □ No
	3a or 28e	i Direc	10e. Street and Number 2553 PERRING	HANOR K		10f. Zip Code		/	. Citizen of What Co	
980	ges 1 end 2 should be filed within 72 hours after deeth with the Maryland it of Heelth and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23a or 28e-f show or other traumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Nerver Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of Yes, specify Co	f Hispanic Origin? (ban, Mexican, Puel lo <i>Specify</i> :	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	i within 72 ho liene. r then "netur the Medical I	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most of wo	orking	Sb. Kind of Business	COMPLEX
Maryland 2	iould be filed I Mental Hygi narked other natic event, I	To Be C	17. Father's Name (First, Middle, Last) TOHN BOAK	RDLEY		·		me (First, Middle, Ma	IKIGHT	-
	end 2 sho leelth and I m 27 is me		19a. Informant's Name/Relationship (7 STEPHANIE L. JOH	HISON (DAVEHTE	X) 255	3 PER		ural Route Number, C	A	Zip Code) D 21234
Baltimore	permit. Pages 1 of Department of He Important: If iten any Injury or oth once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	Removal from State		FUREST Name and Add	fress of Facility	5.05 OK	C. Location - City or VINGS MILL GREENE FOR	US, MARYLAND WERAL HOME
	40244		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	plications that caused the dependence cause on each line.	eath. Do not ente					ARY LAND 2012 Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	equence of):	perter				
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Filter Inderlying Cause (Disease or injury	b. Due to (or as a cons	equence of):	lure	2.	ive		
8760,<	icate be executed physicien and s the burial-transit	dicai Exar	that initiated events resulting in death) Last	Due to (or as a cons	equence of):		entia			
Box 6	ath certif sttending or use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fr 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnar Other (specify)	ncy		23d. Date of de Month	livery Day Year
ds, P.O.	uires that the de signed by the e d be detached t	d by Ph	Part II. Other significant conditions co	ontributing to death but not r	esulting in the ur	nderlying cause	given in Part I.	23e. Did tobac		o the cause of death?
Division of Vital Records,	stclen: The law require certificate has been si rector, page 2 should b	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Vita	ysicien: The is certificate ha director, page	Be	25. Was case referred to medical examiner?	Hospital:		-7	Man Maria	ath (Check only one)	- 5100	
on of	Q. 5. 5	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In	4 A Tursing i	dome 5 ☐ Residence 28d. Describe how		cify)
Divisi	To the Hospitel or Attending Phwithin 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined		t home, farm, streecify)	eet, factory, offic	е	28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	Hospit 24 hour Funere etely fille	Medical (ysician: To the best of my k niner: On the basis of exami and manner stated.						
	To the I within 2: To the I complet	Me	29b. Signature and title of certifier	AL ST			nse number 30115		. Date signed (Mont	h, Day, Year)
	7		30. Name and address of person who of	completed cause of death (It	tem 23a) (Type,	Print)	, Heite	ANO DO	alt. ma	21015
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 2 2005	91 mp 26	nature	9	.10113	116~ 52.	MIT) 17.39	-1213

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 7:25 A M Physician 2005 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4035 St. Augustine Lane Baltimore Dundalk If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5 Social Security Number **Funeral** Hours 1□M 2√2F Yrs Jan. 8,1950 Director Maryland 55 212-60-5328 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location worls d 2 should be filed within 72 hours after deeth with the Maryla. It and Mantal Hygiene. 7 1e marked other than "natural", or flams 23e or 28s-1 show 7 1e marked other than "natural", or flams 23e or 28s-1 show freamatic avent, the Musical Examinatic must be notified at 1 Yes 2 No Dundalk Baltimore Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21222 Completed by Funeral 4035 St. Augustine Lane 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Instructional Assistant 2 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gladys Wolfkill John B. Hanlin, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21222 permit. Pages 1 and 2.
Depertment of Health as Important: If Itam 27 is any injury or other treuome. 4035 St. Augustine Lane Dundalk, Maryland (Husband) Mr. Fred J. Boggs 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/11/2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signatur of uneral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Dnset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure List only one cause on each line. Arter Immediate Cause (Final oronan **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) 4 Pregnant at time of death P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? sete hes been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records. 1 Yes 2 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificete 1 ☐ Yes 🙀 No 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home SEResidence 6 ☐ Other (Specify) 2 No 1 Tes this funeral 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide ō Hospital within 24 hours a
To the Funarel C
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Ş 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M. Schundel D-Physician D39758 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 321, BAUTO, MD, 21237 KEVIN Schendel 9101 Frankin SQ.D., Suite 321, BAUTO, MD, 21237 31. Date filed (Month, Day, Year) AUG 1 2 2005 Registrar

			1 - State Amend Item 10	State of Marylan f&19b per fh	d / Depa G 846 C8-	irtment of H 174-05 tilicate of L	ealth and N Seath	Mental Hygid ਸ ਰ	ene 005	26339
	Physicia /Medic		1. Decedent's Name (First, Middle, Last, William C. Browning					2. Date of Death Month August	Day Yes	/ AM
	Examin		4a. Facility Name (If not institution, give Union Memorial Hospita	·		4b. City, Town, or Baltim		J	4c. County of D	eath
	Funeral Director		219-10-6980	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, September	^(ear) 21, 1924	Birthplace (State or Foreign Country) Maryland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	cation				10d. Inside City Limits
	Mary -faho	tor	Maryland N/A		Baltimo	re				1 Yes 2 No
	h the	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	23a c	aiD	5409 Hillen Road			21212	21239		USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 [∑Yes 2 ☐ No WW] If Yes, Give Year or Dates:	T	Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - A Black, W Specify: W	_
5-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad	cation e com <i>pleted)</i>	(Give I	ent's Usual Occupa	lurina most of wor	king	6b. Kind of Busine	ess/Industry
121	e filed within al Hygiene. I other than " vent, Ine Ve	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		oo NOT use retired, action Worke			Construct	tion
d 2	filed Hygie other ent,		17. Father's Name (First, Middle, Last)		Wilsu	CCTOIT NOT NO		ne (First, Middle, Mi		CIOII
an	Mental Mental rked c	To Be	Earle Harrison Brownin	ng, Sr.			Mabel I.	Pick		
Maryland	shou s mai		19a. Informant's Name/Relationship (T)			•		ral Route Number,		e, Zip Code) 21239
	and 2 ealth m 27 I		Phyllis Browning/Siste			lillen Road	Baltimore	Maryland-		
altimore,	ges 1 t of H If itel or oth		20a. Method of Disposition 1	lemoval from State	emetery, crem	sition (Name of natory or other place	I .		0c. Location - City	
ţ	t. Par rtmen rtant: njury		' 4 ☐ Donation 5 ☐ Other (Specify)		The second second second	rk Cemetery		'05 E	Baltimore M	Maryland
Bal	permi Depa Impo any ir once	1 10	21. Signature of Funeral Service Licens Christina Le	" Unristina L. H Helton	11ton (6)	opard J. Ru Obard J. Ru Ob Harford	Road Balt	imore Mary	and 21214	1
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the deat ne cause on each line.	h. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)			Leake	mid			1 dars.
	/Medical Examiner		resulting in deality	Due to (or as a conseq	uence of):					1 1
Ŀ		e	if any, leading to immediate	Due to (or as a conseq	uence of):					1 day
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Revol Fo	lun					1 day
ó	ficate be executed physician and is the burial-transit	EX	resulting in death) Last	Due to (or as a conseq	uence of):					0
68760,	ate b	edicai		i						
		/Me	IF FEMALE:	3c. If yes, outcome of pregna	ncv				22d Date of	de live ex
Вох	that the death certifi ed by the attending I detached for use as	Physician/M	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
o.	that the de ed by the detached	hysi	1	9☐ Unknown						
0.	res that igned b	by P	Part II. Other significant conditions co	ntributing to death but not res	ulting in the un	iderlying cause give	n in Part I.	23e. Did toba		e to the cause of death?
ord	faw requires as been sign 2 should be							1 🗆 Yes	2 □ No 3 □	Probably 4 Onknown
of Vital Records,	rhe age	ompieted						24a. Was an autopsy perform	prior	
ita	ysician: is certifica director, p	Be C	25. Was case referred to medical examiner?					th (Check only one		
∑ \	Physic this co	P	1 □ Yes 2 2 No		ER/Outpatient		4 Nulsing n	ome 5 Residen		Specify)
on c	ding Ph h. After thi funeral	ion:	27. Manner of Death 1 DNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c, Injury Work	at :? /es 2 □ No	28d. Describe how	injury occurred	
Division	Attending Physician: r death. actor: After this certific by the funeral director.	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he	ome, farm, stre		2010			Rural Route Number,
Ω	al or / s after il Dira	Certi	4 Homicide	building, etc. (Specif	y)			City or Town,	State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai ((Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	wiedge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and place pinion, death occu	, and due to the cau	ise(s) and manner e and place, and c	r as stated. due to the cause(s)
	thin 2 tha tha mplet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29	d. Date signed (M	onth. Day, Year)
	£ 3 £ 8		Shadi Barak	+ IAD						
,	7		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Tvpe. I	AT24			ugust 7,	2000
3	2 '		Shadi Barakat	M.O Union	Memor	ial Hospi	tal, Bd	ltimore, 1	ND.	
	Sta	_	31. Date filed (Month, Day, Year)	32 Registrar's Signa						
	Registr	ar	AUG 1 2 200	5 Menus L	Con	West -				

-		1 - State Amend Item 10 Registrar 1. Decedent's Name (First, Middle, Last)		1 do-ce	rtificate of	Death	2. Date o		2005	263	L Death			
Physic			Rosemarie H	. Boyd			Augu		y, 2005	2:15	Рм			
/Med Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location (of Death		. County of Death	n				
		Suburban Hospital	T		Beth		0.41100		Montgom					
Funera Director		099-22-2347	7. Age (In y. 1M 2⊠F 76	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (Month	Dav. Year	9. Birth Co. 1929 New	nplace (State o untry) York	r Foreign			
land		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside Ci	ity Limits			
Mary a-f sh	tor	Maryland Montgome	ry R	Rockvill	.e					1 ☐ Yes	2 X No			
ith the	Director	10e. Street and Number			10f. Zip Code			10g. C	tizen of What Co	untry?				
s 23a		4533 Hornbeam Dri		11.0	208				ited Sta					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic svent, the Medical Examinating must be rotified at any injury or other traumatic svent, the Medical Examinating must be rotified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 	1	was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 🕅 No		gin? (Specify Yes o n, Puerto Rican, etc.) No-	14. Race - Amer Black, White Specify: Wh	e, etc.				
2 hou atura	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. h	(ind of Business/l	Industry				
ithin 7 19.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	,	t of working	0-	11					
lled w lygier her th		17. Father's Name (First, Middle, Last)	2		Homemake	,	er's Name (First, Mic		vn Home					
d be fi	o Be	Richard L. A. F	lushing			_		aetz	i Sumame)					
shoul nd Me	2	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street	<u> </u>	er or Rural Route No		or Town, State, Z	(ip Code)				
and 2 raith a 127 is er tra	1	Richard Boyd / Hus	band	4533 •	Hornbean	Drive	e, Rockvi	lle, N	laryland	20853				
of He of He If item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20t temoval from State	o. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce) I	August 16	20c. L	ocation - City or 1	Town, State				
Pag tment tant:		*4 Donation 5 ☐ Other (Specify)	Gá	T	ven Cemete	,	2005	Silv	er Spring	, Maryla	nd			
Depar Impor any in		21. Signature of Funery Service Licens Myselle D	mant MO13	05 Rc		mphrey tgomery	Funeral Ho Avenue, Ro		kville, Ii e, Marylar	nc. nd 20850-	-2805			
Pnysician		23a. Part 1. Ender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Urosepsis Approximate Interval Betwoen Constitution												
/Medical		resulting in death)	Due to (or as a cons	sequence of):		-								
_xammer		Sequentially list conditions, if any learning immediate cause. Enter Underlying	Due to (or as a cons		ing Urina	ary Ca	atheter							
uted d ansit	Examine	Cause (Disease or injury	Bladder		is				-					
an and rial-tra		that initiated events resulting in death) Last	Due to (or as a cons	sequence of):										
icate be executed physician and s the burial-transit	dicai		Malnutri	tion										
he death certificate be executed the attending physician and shed for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3[⊒Ectopic pregnanc ⊒ Other (s <i>pecify</i>) _	у			23d. Date of deli Month		Year			
es that the de igned by the a be detached t	by Ph	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause gr	ven in Part I	. 23e. l	Did tobacco	use contribute to	the cause of d	leath?			
w require been sig should b	ed b							☐ Yes 2	No 3□ Pro	obably 4 □U	Jnknown			
The taw requires that the rate has been signed by th page 2 should be detached	completed							Vas an lutopsy lerformed? es 2∑N	nrior to c	topsy findings a completion of ca	available ause of			
certifica rector, l	Be C	25. Was case referred to medical examiner?					of Death (Check o			15-10-				
Phys this al dia	P	1 ☐ Yes 2 🛣 No		ER/Outpatie	1 3 DOA	TO SAFETY OF THE SAFETY	ursing Home 5 🗆 F			cify)				
	ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wo	ryat irk?]Yes 2□		ibe how inju	ury occurred					
Hospital or Attanding 14 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	at home, larm, st ecify)	reet, factory, office			on (Street a Town, Stat	nd Number or Ru e)	ıral Route Num	ber,			
To the Hospital of within 24 hours at To the Funeral D completely filled in	Medicai (29a. Certifier 12 Certifying Phyone) 2 Medical Exami	ner: On the basis of exam and manner stated.	knowledge, Jean nination and/or in	n occurred at the to vestigation, in my	ime, date an opinion, dea	id place, and due to th occurred at the ti	the cause(s me, date ar	s) and manner as ad place, and due	stated. to the cause(s	;)			
To the within 2 To the complet	M	29b. Signature and title of certifier	< i.	JilKs	29c. Licen	se number		29d. Da	ate signed (Month	n, Day, Year)				
		> STUV	7, 4	of hea	D00	063195)	Aug	ust 10,	2005				
7	- 1	30. Name and address of person who co				D +1	1 - M	.1	2001/					
30	-	Steve Wilks, M.D.	8600 01d G	eorgeto	wn koad.	Bethe	esda, marv	rand	20014					

			For	State of Maryla	and / Depa	artment of H	ealth and	Mental Hygi	ene	
			1 - State Registrar		Cei	rtificate of L	Death		1. N2 0 0 5	26341
П	Physici	an	Decedent's Name (First, Middle, Last)		0-4-1-			2. Date of Death Month	Day 7 Year 7, 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	vid Beltran street and number)	-cataia	4b. City, Town, or	Location of Dea	August	4c. County of Dea	
h	- Zamini	Ŭ.	5804 Tang1	ewood Drive		I	Bethesda		Mon	tgomery
	Funeral		5. Social Security Number 6. Sex	M 2DF	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day,)		thplace (State or Foreign ountry)
	Director		220-49-6988 Usual Residence of Decedent	4.	5 113.			November 1	2,1959	Spain
	ryland thow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f s	Director		gomery			Bethesda			1 ☐ Yes 2 No
	with the or 2		10e. Street and Number	1 Design		10f. Zip Code	20017	100	g. Citizen of What C	
	ms 23	Funeral		ewood Drive 12. Was Decedent Ever in	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	20817 spanic Origin? (Specify Yes or No-	14. Race - Am	
စ္တ	after or Ite	/ Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give		irYes, speciny Cuba 1 □ Yes 2 🛣 No	n, Mexican, Pue. Specify:	по нісап, etc.)	Black, Whi	te, etc.
8	hours tural',	d by	3 Widowed 4 Divorced	Year or Dates:						White
7	be filed within 72 hours after death with the Maryland tal Hygiene. Id all Hygiene. Id other than "natural", or terms 23a or 28a-f show other than "natural", or terms 23a or 28a-f show event, the Madical Examirer must be notified at	Completed	(Specify only highest grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of wo	orking	8b. Kind of Business	vindustry
212	od with	Com	Elementary/Secondary (0-12)	5+		Lawy	/er		Banl	king
Ind	be filed Ital Hygir Id othar	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma	uiden Sumame)	
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked othar than aumatic evant, the M	^L	Ado 19a. Informant's Name/Relationship (Ty	lfo Beltran	19h Mailir	on Address (Street	and Number or F	Pilar	Catala	Zin Codel
Z S	nd 2 s lith an 27 is r trau		Carmen Arguelles/	_		87.		, Bethesda		
Jre,	of Head		20a. Method of Disposition	20	h Place of Dispo			Date 20	c. Location - City or	
altimore,	Page ment ent: if		1 ☐ Burial 2 🕅 Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Cremato	orium Inc.	. ' -a	gust 2005	Bethesda,	Maryland
Ball	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic es once.		21. Signature of Funeral Service Licens	/ /	0335 Be	Name and Address thesda-Cl ethesda, I	ss of Facility Ro nevy Cha Maryland	bert A. Pi se Inc 20814-350	imphrey Fi 755/ Wisco)1	uneral Home/ onsin Avenue
П			23a. Part1. Enter the disease, excompt shock, or heart failure. List only or	cations that caused the done cause on each line.	leath. Do not ent	er the mode of dying	g, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Metastati		ancer				6 Months
н	Examiner		- 1	Due to (or as a con	sequence of):					
	ъ =	Iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a con-	sequence of):	·	·			
_	Attending Physician: The law requires that the death certificate be executed and death. and death. actor: After this certificate has been signed by the attending physician and actors the funeral director, page 2 should be detached for use as the burial-transit.	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
760,	sician buria	icai E		4						
89	tificate ng phy as the	ed								
Вох	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 Live birth 2 □ F	etal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
P.O.	he deg	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	of death 5	Other (specify)				22)
۳.	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
Records,	w require: been sig should be							1 X Yes	2 □ No 3 □ P	robably 4 Unknown
ecc	law re las be	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
E E	: The							performe	ed? death? ☐ No 1 ☐ Yes	s 2 No
<u> </u>	siciar certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatier	nt 3 DOA Othe		ath <i>(Check only one)</i> Home 5 X Residen	oo 6 MOthor (Sar	noife!
o t	ding Physician: The lav h. After this certificate has funeral director, page 2	-	27. Manner of Death	28a. Date of Injury (Month, Day Year				28d. Describe how		scriy)
Sior	endin eath. or: Aff	catio	1 🛣 Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	(,,,		Yes 2 □ No			
=	tai or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, str ecify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or A State)	ural Route Number,
	To the Hospital or Attent within 24 hours after death To tha Funerel Diractor: completely filled in by the	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my ner: On the basis of exam and manper stated.	knowledge, death nination and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	e, and due to the cau surred at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	with Tot	Σ	29b. Signature and title of conflier) /		29c. License	number	290	I. Date signed (Mon.	th, Day, Year)
•	1.6	>	+ /	10	He= 00=1 7		00003329	3	August	8, 2005
	14		30. Name and address of person who co			•	ie #1300	Chevy Cha	ise. Marvl	and 20815
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	al .	"1500	onevy one	, mary	20013
	Registr	ar	AUG 1 2 20	05 Angues	Di An	and I				

			For State Registrar		State of M	aryland		artmen tificate			and Me	ental Hy	giene	005	263	42
	Physici	an	1. Decedent's Name	e (First, Middle, Las	t)		0	leave	els!		2	2. Date of De Month	Day		3. Time o	14
	/Medi	cal	4a. Facility Name (f not institution, give	street and number)		130 m	Kow.		Location o	of Death	gug vst		200 County of Dea		35m'
	Examir	ner	1	Hookins	11]	1		Bolt			Citz	,	10.	NA	2111	
	Funeral Director		5. Social Security N 212-48-5	6. So 107		e (In yrs. Ias		If Under Months		If Under 2 Hours	Min.	B. Date of Bi (Month, Di IOV. 2	rth ay, Year) 8, 19		rthplace (State country)	
	land ow		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Lo	cation							10d. Inside (City Limits
	Mary P-f sh	to	MD	Baltimor	re	Rose	dale								1 □ Ye:	2 📉 No
	th the	by Funeral Director	10e. Street and Nur	mber				10f. Zip	Code				10g. Citi	zen of What C	ountry?	
	ath wi	rai	8123 Woo	dhaven Ro				212					U.S.	Α.		
	ter de Items	nue	11. Marital Status	ind 2 Th Marriad	12. Was Decedent Armed Forces?		. 13. \	Nas Deced f Yes, spec	lent of His offy Cubar	spanic Orig n, Mexican	gin? (Spec , Puerto Ri	ity Yes or Nican, etc.)	0-	14. Race - Am Black, Wh		
036	urs af	by	3 Widowed	ied 2 Married 4 □ Divorced	1 □ Yes 2 □ If Yes, Give Year or Dates:			I□Yes 2	2 ⅓ No	Specify:				Specify: Wh	ite	
5-0036	72 hours after death with the Maryland neture!', or Items 23e or 28e-f show Jisal Existill serf nati be incilised at	Completed	(Spec	15. Decedent's Ed			16a. Deced	lent's Usua kind of wor			of working	7	16b. Kii	nd of Busines	s/Industry	
2121	within ene. then *	m p	Elementary/Seco		College (1-4or	5+)	life. L	OO NOT us	e retired)) -						
	filed v Hygie other t	e Co	17. Father's Name	(First, Middle, Last)			Accou	ints i	-		r's Name (First, Middle		ation		
lan	should be filed within 72 hours after dea nd Mental Hygiene. marked other than "neturel", or Items matic event, Ire Modics Ext., il refr.,	To B	Louis St	achowiak						Dori	s Prz	ybylsl	ki	,		
Maryland	S as as		19a. Informant's Na	ame/Relationship (7	ype, Print)		19b. Mailir	g Address	(Street a	nd Numbe	r or Rural i	Route Numb	er, City o	r Town, State,	Zip Code)	
- 10	1 and Health Health Stem 27 other tr			Bonkowsk	i/spouse	20h Dia	8123	Woodh	naver	Road		sedale				
Baltimore	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr once.			☐Cremation 3 ☐	Removal from State	cen	ce of Dispo netery, cren	natory or of	ther place		Da 13/0/			cation - City o		a
i	permit. Pages Department of Importent: If it eny injury or c			5 Other (Specify		Gard	dens c	of Fai							Marylan ral Hom	
B	permit. Departr Importe eny inje		> C	- a	70							Rose			1237	е
	Physician /Medical Examiner	The state of the s	23a. Part1. Enter to shock, or hea Immediate Cause disease or condition resulting in death)	rt tailure. List only (Final	a. Due to (or as	a conseque	nce of):				cardiac or		arrest,		Approxima Interval Be Onset and	tween
8760, K	ate be executed hysician and the burial-transit	cal Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) I		b. Out to (or as c. Gost Due to (or as	a conseque		car			Tee C				20 ma	intrs
P.O. Box 68	t the death certific by the attending p ached for use as	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal d	eath 3□	Ectopic pre					2	3d. Date of de Month	,	Year
	w requires that been signed should be det	þ	Part II. Other signif	icent conditions co	ontributing to death b	ut not resulti	ing in the ur	nderlying ca	ause give	n in Part I.		_			o the cause of robably 4	death? Unknown
I Records,	The ate h page	Completed										24a. Was auto perfe 1 \(\text{Yes}			utopsy findings completion of	
Vital	Physicien: this certific ral director,	Be	25. Was case refer examiner?		Hospital: 💥				Othe	~		Check only				
of	≥ .º. o	.: To	1 Yes 2	NO	28a. Date of Inju	rv 2	NOutpatien 8b. Time of			4 🗆 Nur		5 Resi		Other (Spe	ecify)	
ion	Attending Fir death. ector: After by the funer	atlor	1 Natural 2 Accident	5 Pending investigation	(Month, Da	y Year)	Injury	М	Bc. Injury Work' 1 □ Y	? ′es 2 □ N						
Division	in Qiffe	Certification:	3 Suicide 4 Homicide	6 Could not be determined	280. Place of in	ury - At hom c. (Specify)	e, farm, stre	eet, factory,	, office		28	f. Location (City or To	Street and wn, State)	d Number or F	tural Route Nur	nber,
	To the Hospitel within 24 hours a To the Funerel completely filled	edical	29a. Certifier (Check only one)	Certifying Phy 2 Medical Exam	/sician: To the best iner: On the basis o and manner st	f examination	edge, death n and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	h occurred	at the time,	date and	place, and du	e to the cause(
	To t To t	Σ	29b. Signature and	title of certifier					. License				29d. Date	signed (Mon	th, Day, Year)	-
•	/		1/2	71-	-1				ES.	-00	0		Aug	11 tcu	, 200	5
	5		Robert 31. Date filed (Mon	c Swil,	MDPhD	John John ar's Signatur	3 Hopi	Print) KINJ	1601	ortal	1600	NW	olec	St/Ba	th, Day, Year) 200 Homor	e, MD
	Sta Registr	100		2 2005	Elecus !	J.	boute	,								1287

			1 - For State Registrar	State of Mary	rland / Depa		lealth and	Mental Hygi	ene g. N2 0 0 5	2631.3
	Physici /Medi		1. Decedent's Name (First, Middle, L Angelette Berg	ger				2. Date of Death Month August 7	Day Year	3. Time of Death 12:30 PM
	Examir Funeral	ner	4a. Facility Name (If not institution, g Stella Maris F 5. Social Security Number 6.	Nospice Sex 7. Age (In	yrs. last birthday)	4b. City, Town, of Timoniu If Under 1 Year Months Days	m If Under 24 Hrs Hours Min	8. Date of Birth	4c. County of Deat Baltimor 9. Birt	
	Director		220-07-1548 Usual Residence of Decedent 10a. State 10b. County	1□ M 2∏F 90	Yrs. c. City, Town or Lo		Tiours IVIII	Mar 3, 1		10d. Inside City Limits
	th the Mary or 28a-f sh	Director	MD Baltimo	ore	Timon	i.um 10f. Zip Code		10	g. Citizen of What Co	1 ☐ Yes 2 No untry?
000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel', or items 23e or 28a-f show any injury or other treumetic event. The Marical Examination and once.	by Funeral D	2300 Dulaney Va 11. Marital Status 1 Never Married 2 Married 3 Divorced	12. Was Decedent Ever Armed Forces?		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 💢 No	21093 dispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	USA 14. Race - Ame Black, Whit Specify: wh	e, etc.
21212-0030	within 72 houne. ne. than "nature is Mudical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Grade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo d)	rking	6b. Kind of Business/	Industry
yiand z	ould be filed v Mental Hygie arked other t atic event, In	To Be Co	12 17. Father's Name (First, Middle, La Carroll Creswe		teac	her		me (First, Middle, M Baldwin	educatio alden Sumame)	n
Mar	s 1 and 2 sho if Health and I Item 27 is me other treume		19a. Informant's Name/Relationship James Berger/sor 20a. Method of Disposition	1 2	205 Ob. Place of Dispo	Belmont	Forest C	t #404 Ti	City or Town, State, 2 nonium MD oc. Location - City or	21093
ballimore,	permit. Page Department o Importent: If any injury or once.		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☒ Other (Special Control of Contr	city) in state	tor si	Name and Addre	ess of Facility Omy Boar		Baltimore	Street
	Pnysician /Medical		23a. Part1 Enter the disease, o co shock or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. ISCHEMIC Due to (or as a co	death. Do not ent		MD 212 ng, such as cardia	O1 c or respiratory arres	st,	Approximate Interval Between Onset and Death
,0070	ate be executed hysician and he burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a co						
o You .	ihe death certificat r the attending phy ched for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy	/		23d. Date of deli Month	very Day Year
, L (SD)	The law requires that the death ate has been signed by the atte page 2 should be detached for	by	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause giv	ren in Part I.		acco use contribute to	the cause of death?
	The la ate has page 2	Completed						24a. Was an autopsy perform 1 Yes 2	prior to death?	topsy findings available completion of cause of 2 No
SION OF VITAL	ng Phys fter this	ertification; To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending investigate	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 ☐ Nursing H	ath (Check only one, dome 5 ☐ Residen 28d. Describe how	ce 6 X Other (Spec	HOSPICE
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	O	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	building, etc. (S	pecify)	•		City or Town,	,	
	o the Hospitel or thin 24 hours after the Funerel Dire mpletely filled in I	Medical	29a. Certifier (Check only one) 2 Medical Ex	Physician: To the best of my aminer: On the basis of exa and manner stated.	y knowledge, death imination and/or in-	n occurred at the fir vestigation, in my o				
	with To		1			D4	J725	290	1. Date signed (Month	05
			30. Name and address of person wh DR. TARIQ MAHN	100D 2300 DU	LANEY VAI		TIMONIU	M, MD 210	93	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 2 20	05 Registrar's S	Signature	de la				

DHMH 17 Rev 1/2001

AUGUST 7, 2005

ANGELETTE BERGER

			. For						d Mental Hy	giene.		00011
		_	- State Registrar			Cei	tificate of	Death			2005	26344
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Exar	nine	r	4a. Facility Name (II not institution, giv 128 West 3rd S		")		Frede		704(11	40.	Frederi	_
Funer	al		5. Social Security Number 6. S		Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bird Min. (Month, Da	th V Voarl	9. Birth	place (State or Foreign intry)
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and w		-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
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r 28a		i ec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	
illu A I A I 300030 be filed within 72 hours after death with the Maryland tal Hyglene. Identar than "netural", or items 23e or 28e-f show went the Medical Examiner must be notilised at	:	Funeral Director	128 W. 3rd Stree	t				21701			USA	
r dea		nue.	11. Marital Status	12. Was Deceder Armed Force	s?	S. 13.	Was Decedent of H I Yes, specify Cubi	lispanic Origin an, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)	- 1	 Race - Amer Black, White 	
s afte	'	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give Year or Dates	□ No		1 □ Yes 2√ No	Specify:		1	Specify: whi	ite
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hin 72 Median		ble	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4c	or 5+)	(Give life.	kind of work done DO NOT use retire	during most of d)	f working			
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S 1 ag f Hea item; other		ŀ	20a. Method of Disposition		C	face of Dispo	sition (Name of matory or other place		Date		cation - City or 1	own, State
Page nent c ant: If			1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☑ Donation 5 ☐ Other (Specil		te	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		1			
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	9		23a. Part 1. Enter the disease, or comshook, or heart lailure. List only Immediate Cause (Final	one cause on each	sed the death	n. Do not ent	_			rrest,		Approximate Interval Between Onset and Death
Physicia /Medic			disease or condition resulting in death)	a _ fa	YKI	7300	D13	east	/			5 years
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VICAL MECOLOS, P.O. DOX 00/ sician: The law requires that the death certificate certificate has been signed by the attending phys recor, page 2 should be deteched for use as the		Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			7			2	23d. Date of deli-	very
death death e atte		icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	at time of de		Ectopic pregnanc Other (specify) _	у			Month	Day Year
at the lby the etache		Phys	9 Unknown			-			on- Did			the source of death?
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w requires to been signed should be		Completed							24a. Was			topsy findings available
ne law has		d L							autor	psy ormed?	prior to c	ompletion of cause of
in: The		ပို	25. Was case referred to medical					26 Place o	1 ☐ Yes f Death (Check only of	20X No	1 L Yes	2 No
Of VICE Physician: rthis certific ral director,		0	examiner? 1 Tes 2 No	Hospital:	atient 2 🗆	ER/Outpatier	nt 3 DOA Oth	her: 4 🗆 Nursi	. /		5 □Other (Spec	ify)
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SIOI leath. or: A		catic	2 Accident investigatio		_			Yes 2 □ No		_		
OVISION Tor Attending after death. Director: After the fune	.	Certification:	4 Homicide determined	200. Place U	Injury - At ho etc. (Specify	ome, larm, sti	reet, lactory, office		281. Location (City or To			ral Route Number,
To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: Attenthis certificate his completely filled in by the funeral director, page			29a. Certifier f⊠ Certifying P	nysician: To the be	st of my kno	wledge, deat	h occurred at the tr	me, date and	place, and due to the	cause(s)	and manner as	stated.
ne Hos ne Fur letely		edicai			s of examinal				occurred at the time,			
To th withir To th		Me	29b. Signature and title of certifier				29c. Licens				e signed (Month	
			AN	- Sho	zh t	Hom	mo	051	643	6/	5/05	
			30. Name and address of person who	completed cause of	ol death (Item	3 23а) (Туре,	Print)	T	6y3 denols	/		17.0
	Stat	0	31. Date filed (Month, Day, Year)	nas Regi	strar's Sigga	ture	UN	rec	ences		np a	1 102
Pos	olal		AUG 1 2 200	15 19000	1	200	Es .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 750 A M **Physician** Elizabeth W. arke 2005 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Olumbia Howard County General Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) FEB. 28, 1 **Funeral** Months Days Hours 217-80-6327 1 ☐ M 2 🖫 F 96 1909 Scotland Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examble must be nutitied at once. 10a State 10b. County 1 ☐ Yes 2 X No Director Marvland Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 3036 Patuxent Overlook Court 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 N Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
Unk. College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Unk. Unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3036 Patuxent Overlook Ct. Ellicott City, MD 21042 Deborah L. Herman/Personal Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 8/10/05 Baltimore, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Fundral Service Licensee McDonald 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset, and Death Immediate Cause (Final disease or condition pheumonia 2 days **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy ō Month Day Year 5 Other (specify) signed by the at d be detached fo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ementia 1 ☐ Yes 2 No 3 Probably 4 Unknown should peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No Anemia 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No To the Hospital or Attending Physicien: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ۲ 2 ER/Outpatient 3 DOA this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No in by the 24 hours after deat e Funeral Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 [] Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fun completely f 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.P. 56531 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ridge Rd, Columbia, MD 21044

10780 Hickory

32. Registrar's Signature

Blown & Spark

DHMH 17 Rev 1/2001

State Registrar Harry

31. Date filed (Month, Day,

41

Amend item#23arII,25,27,28a-I, perME, G846,8/II/05 II Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Ne. 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:55p Ruby J. Cope July 3 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Lorien Nursing Home Carroll Mt. Airy
If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 1 F Yrs. Director 85 July 27, 1919 217-58-2470 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County show in than "natural", or Items 23a or 28a-f show The Medical Ever in at must be notified at 1X Yes 2 No Completed by Funeral Director Maryland Carroll Mt. Airy 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21771 7903 Circle Drive United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☑ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) s 1 and 2 should be filed w f Health and Mental Hygier item 27 Is marked other th Homemaker Own Home item 27 Is marked othe other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Henley Hopkins Musa Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Kohlhepp/ Daughter 5934 Woodbine Road #4, Woodbine, Maryland 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite
any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Liberty Baptist Cemetery 7/7/05 Lisbon, Maryland 22. Name and Address of Facility
Olin L. Molesworth P. A. Funeral Home
26401 Ridge Road, Damascus, Maryland 20872 21. Signature of Funeral Se Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician Pulmonand OBSTAUGHT TISEASE 4EA Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Vear Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f o ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records. FRACTURES 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hypertensive Arteriosclerotic cardiovascular disease: 24a. Was an formed2 2 No Atrial fibrillation 1 Tyes of Vital Hospital or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 Pending 2 Accident 1 ☐ Yes 2 XNo after death. Director: A 6/29/2005 12:10 PM investigation subject fell 6 Could not be determined 288. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

nursing home/ assisted living facility Midway Ave. Mt Airy, 3 Suicide 4 Homicide filled in within 24 hours a To the Funeral E 29a, Certifier criffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cer D31912 July 5, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julio Menocal MD 1564 Opossumtown Pike, Frederick, Maryland 21702 31. Date liled (Month, Day, Year) State JUL 0 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 10:15pmm Darie1 S. Corbin August 7,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 53 408-88-8641 Director Feb.19,1952 New Jersey Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Modical Execution count be notified at MD Montgomery Silver Spring 1 Yes 2 □ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 11200 Lockwood Drive Apt. 1714 20901-4546 USA or Items 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ★Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or othar traumatic avant Elementary/Secondary (0-12) College (1-4or 5+) Government Management Consultan 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ERnest Burgans Pauline Coleman ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4617 Hancock Road Chattanooga, TN 37416 Ernest Burgans/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 13, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State
1 4 ☐ Donation 5 ☐ Other (Specify) Obfer Cemtery Decatur, IN 2005 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc 1501 Fast Fort Ave Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Large Intracereberal BLeed days /Medical Due to (or as a consequence of) **Examiner** Hypertension years Sequentially list conditions, if any, leading to immediate cause. Enter the Jack of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Mo Month Dav Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 218 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 SNo 1 Mnpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attanding Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number A. Namaz. up D 50987 8-8-05. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AHMED NAWAZ PO BOX 83 THERSBURY MO20883 83819 31. Date filed (Month, Day, Year) AUG 1 2 2005 82. Registrar's Signature State loca & sperte Registrar

			1 - State of	Maryland / Depa Ce	artment of Heartificate of De			ene 9. Ng2 () ()	5 2631.8
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	/Medi Examir		4a. Fecility Name (If not institution, give street and numb		4b. City, Town, or Lo	cation of Deeth		4c. County of D	Death
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Ē	Funeral Director		5. Social Security Number 6. Sex 7. 1 M 2 F 7.	Age (In yrs. last birthday) 79 Yrs.		Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, 1)	9. 1925 M	Birthplace (Stete or Foreign Country)
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9036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23e or 28e-f ehow Ita Modleal Eventinet must be rotified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? No	Was Decedent of Hispa II Yes, specify Cuban, M 1 ☐ Yes 2 No S	anic Origin? (Speci Mexican, Puerto Ri Specify:	ify Yes or No- can, etc.)		American Indian, White, etc. White
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21	filed will Hygien other th	Con	10 yrs.	Ca	shier			Food Store	
Maryland 21215-0036		To Be	17. Father's Name (First, Middle, Last) Robert R. Pilkerton		18	. Mother's Name (First, Middle, Ma la Hoope		
	nd 2 shallth and 27 Is m		19a. Informant's Name/Relationship (Type, Print) John H. Douglas son		ng Address (Street and Belvue Drive				e, Zip Code)
Baltimore,	Pages 1 a lent of Hea nt: # item ry or othe		20a. Mathod of Disposition 1 Surial 2 Cremation 3 Removal from Sta 4 Donation 5 Other (Specify)	20b. Place of Dispo cemetery, cred cak Lawn O	natory or other place)	Aug 16, 200	20 05 I	oc. Location - City Baltimore	or Town, Stete
Balti	permit. Pages 1 Department of He Importent: If iten any injury or oth		21 Smallure of Fundral Savice Licensee		Name and Address of nnelly Funera 110 Sollers P	f Facility 1 Home Of I	Andalk		
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	/Medical Examiner		resulting in death)	as a consequence of):	· 0	~solli	· · · · ·	- 114	montens
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O. Box 6	death certifi e attending p id for use as	Physician/Med		n 2 ☐ Fetel death 3 ☐ t at time of death 5 ☐	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ص	requires that the een signed by th hould be detache		Part II. Other significant conditions contributing to deat	h but not resulting in the u	nderlying cause given in	n Part I.	23e. Did toba	cco use contribute	e to the cause of death?
rds	quires n sign	d by	anemia cor	s recon	+ mi		1 ☐ Yes	2 □ No 3 □	Probably 4 Onknown
l Records,	The law ate has b page 2 sl	Completed					24a. Was an autopsy performe	prior death	
Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical		26	. Place of Death (0	1		55.10
of <	dis dis	70	1 Tes 2 No decline Hospital: 1 Inp.	atient 21 En utpatien	t 3 DOA Other:	4 Nursing Home	5 Residence	ce 6 Other (S	(pecify)
0	ng Ph Iter th Ineral		27. Manner of Death 28a. Date of I	njury 8b. Time of Injury	28c. Injury at Work?	280	d. Describe how	injury occurred	
sio	eath. or: A the fu	cati	2 Accident investigation		M 1 ☐ Yes	2 🗆 No			
Division	tal or Att rs after d el Direct ed in by l	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building.	Injury - At home, farm, streetc. (Specify)	eet, factory, office	281	Location (Stree City or Town,)	et and Number or State)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the beside and manner.	s of examination and/or inv	occurred at the time, overtigation, in my opinio	date and place, and on, death occurred	d due to the caus at the time, date	se(s) and manner e and place, and c	as stated. due to the cause(s)
)	To t To t	2	29b. Signature and title of certifier	>	29c. License nu	mber 5 8 4 3		Date signed (Mo	*
	10		30. Name and address of person who completed cause of Thomas in the completed cause of the cause of the cause of the completed cause of the cause of the cause of the cause of the caus		Print) Derr	85m.3	JME	smc	
п	Sta	te	31. Date liled (Morth, Gay, Year) 2005 32. Regi	strar's Signature	232 3				

			For State Registrar	State of M	aryland / I		artment of <i>tificate of</i>		nd Mer		ene 0 0	15	26349
	Dharisi		1. Decedent's Name (First, Middle, Las	t)	-					Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic		Margaret Ellin C	romer								005	2255 ^M
	Examin	er	4a. Facility Name (If not institution, give)		4b. City, Town,		Death		4c. County		
			Suburban Hospita 5. Social Security Number 6. Se		ge (In yrs, last bi	rthdoul	Beth If Under 1 Yea		4 Hrs To I	Date of Birth	Mot	ntgom	ery ace (State or Foreign
	Funeral Director			M 25kF	76	Yrs.	Months Day		Min.	(Month, Day,	Year) 1928	Coun	ington DC
			Usual Residence of Decedent				1			10-31-	1920	Wasii	Ington be
	yland		10a. State 10b. County		10c. City, Tow	vn or Lo	cation					10	Od. Inside City Limits
	a-fs	ctor	MD Montgo	mery	Betl	hesd	la						11∑Yes 2 No
	be filed within 72 hours after death with the Maryland ital Hyglene. id other then "natural", or Itams 23a or 28a-f show odher then "natural", or Itams 21a or 28a-f show evant, the Medical Exam har must be notified at	al Director	10e. Street and Number 7425 Democracy B	1vd #11			10f. Zip Code	20817		10	g. Citizen of W USA	hat Coun	try?
	ams	Funeral [11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Was Decedent of f Yes, specify Cu	Hispanic Origii ban, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)		e - America k, White, e	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ If Yes, Give	No		1 ☐ Yes 2 ☒ N	o Specify:				Whi	
Ö	hours tural		3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	160	Dogg	dent's Usual Occi	Instice			6b. Kind of Bu	sinoso/lns	hiotori
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12	within iene. t hen "	шо	Elementary/Secondary (0-12)	College (1-4or	5+)	Но	memaker				Own	Home	
b	e filed value other to	a	17. Father's Name (First, Middle, Last)					18. Mother's	's Name <i>(Fi</i>	rst, Middle, M	aiden Sumam	e)	
Maryland 21215-0036	should be not marked ourmatic eva	To B	Warren Eller Wel		101	h Mailir	ng Address (Stree		_	Edna		State 7in	Cadal
	ages 1 and 2 should b nt of Health and Ments t: If item 27 le marked / or other traumatic e		Michael S. Crome			985	Forrest		mphis	, TN 3	8105		
ore	Pages 1 nent of H int: If itel		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Removal from State	cemete	ery, cren	sition (Name of natory or other pi		Date		Oc. Location		
ţį	tment: tant:	10	`4 □ Donation 5 □ Other (Specify)	Cnesa		ke Crem		08-10	-2005	Beltsv	'111e	MD
Baltimore,	permit. Page Department of Important: If any injury or once.	l la	21. Signature of Funeral Service Lices Style & Sohn	mann	M0038Z	22	Name and Add Rapp Fur 933 Gis	neral &	Crem	ation Sprin	Service g MD 20	910	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that cause one cause on each	d the death. Do line.	not ent	er the mode of dy	ying, such as ca	ardiac or re	spiratory arre	st,		Approximate Interval Between
	Physician	i u	Immediate Cause (Final disease or condition	a End-St	age COPI	D							Onset and Death 1 week
	/Medical Examiner		resulting in death)	и	s a consequence								
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b		0							
	pe is	ine	if any, leading to immediate cause. Enter Undertying Cause (Ciesause of Injury	Due to (or a:	s a consequence	of):							
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	s a consequence	of).							
8760,	be e) ician buria	a E		24010(0.4.		J.,.							
387	phys phys s the	dical		d									
9 X	The law requires that the death certificate has been signed by the attending is age? Should be detached for use as	/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy						23d Date	e of delive	rv
Вох	atter atter I for u	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death		Ectopic pregnan Other (specify)	су			Mor		Day Year
0	t the de by the a	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
<u>α</u>	that ned b	by PI	Part II. Other significant conditions o	ontributing to death	but not resulting	in the u	nderlying cause g	jiven in Part I.		23e. Did toba	acco use contr	ibute to th	e cause of death?
ds	quires n sign ald be						-		_ 4	t x XYes	2 □ No	3 Proba	abiy 4 Dunknown
Records,	w require s been si should?	ompleted								24a. Was an	24b. V	Vere autor	osy findings available
Re	The lavate has	E C							_	autopsy perform	ed? d	rior to con leath? Yes	npletion of cause of
Vital		O	25. Was case referred to medical					26. Place o		1 ☐ Yes 2- heck only one	21		2 140
>	Physicien: this certific ral director,	O.B	examiner? 1 ☐ Yes 2 ☑ X lo	Hospital: 17 Inpat	ient 2 ER/O	utpatien	t 3 DOA	thor			nce 6 Othe	ar (Specify	-)
ı of		P.	27. Manner of Death	28a. Date of Inj (Month, D	ury 28b.	Time of	28c. Inj W				v injury occurre		
0	Attending I r death. ector: After by the funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		.,	,		☐Yes 2☐No	0				
Division	iel or Attendii s after death. el Director; A ed in by the fu	ertification;	3 Suicide 6 Could not be determined	200. Flace UI II	ijury - At home, fa	arm, str	eet, factory, office	9	28f.	Location (Stre City or Town,		or Rural	Route Number,
	ppitel or ours afte serel Dis filled in	Cer		3,									
	4 to 100 de la 1	edical	29a. Certifier 1 (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the bes iner: On the basis and manner s	t of my knowledg of examination ar tated.	e, death nd/or in	n occurred at the vestigation, in my	time, date and opinion, death	place, and occurred a	due to the car it the time, da	use(s) and mar te and place, a	ner as stand nd due to	ated. the cause(s)
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	. 0				nse number	0.1	29	d. Date signed		
	/		· Unchen m	(リ			D	00616	001		8-7	-00	0
	5		30. Name and address of person who	completed cause of	death (Item 23a)	(Туре,	Print)						
	,		Natasha Chen 860	0 01d Geo	rgetown	Rd.	Bethes	da MD 2	.0814				
	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 9 2	32. ghs	rar's Signature	A	in the						

Margaret cromer 18-6-05 @ 2255

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrer Certificate of Death Reg. Ng? Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 13.33 M AUG Geraldine F. Cookerly 2005 /Medical 4b. City, Town, or Location of Death BALTIMORE 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ST. AGNES HEALTHCARE N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sep. 15, 1 **Funeral** Birthplace (State or Foreign
Country) Months Days Hours Min 1 □ M 2 □ F 406-32-4909 75 Director 1929 Kentucky Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23a or 28a-f ehow any Injury or other traumatic event, the Medical Examt are must be notified at once. 1 ☐ Yes X ☐ No MD Director Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4230 Hollins Ferry Rd., Apt. 108 21227 Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Flem Lafayette Frazier Ethel Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3003 Dunmore Rd., Dundalk, MD 21222 Jeannie Marsh, Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Good Shepheid 1☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cemetery 8-11-2005 Ellicott City, MD 21. Signature of Funeral Service License 22 Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Ferry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCREATIC METASTATIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4☐Pregnant at time of death 5 Other (specify) Ö 9□ Unknown Division of Vital Records, P. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď ACUTE REMAL FAILURE been signature 1 Yes 2 No 3 Probably 4 Unknown Completed HYPONTREMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 21 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 SInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After t 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending M 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DR P06062 A46 08,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEALTHCARE, BALTIMORE, MD 21229 ST. AGNES 31. Date filed (Month, Day, Year) 32. gistrar's Signature State 2 2005 Registrar

DHMH 17 Rev 1/2001

Jokerly, Geraldine

Amend item#1, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death James Henry Clay Jr. Day Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SILVER MONTOUM 7. Age (In yrs. last birthday) **Funeral** Social Security Number 6. Sex Birthplace (State or Foreign Country) Days 13 M 2□ F Months Hours Min 578-46-3570 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 ehow other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ res 2 ☐ No 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: UNK 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry filed within 7 Hygiene. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) TER INTERIOR DECORATING 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DRGIA ELDER ST. NW WASHINGTON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State INATOMY GIFTS KEG * 4 Donation 5 □Other (Specify) 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 23a. Parv. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifications and the property of th 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Chath 28a. Cate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 060826 30 Shama 30. Name and address of person who completed cause of death (Item/23a) (Type, Print) 500 TOCREST GLEN RD. SILVER SPRING, MD. 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2005 AUG 1 Registrar

		1	For State Registrar	State of Marylan	d / Department of F Certificate of			iene g. Ner 005	26352
	Physicia		Decedent's Name (First, Middle, La	*			2. Date of Death	Day Year	3. Time of Death 4946 PM
	/Medic Examin Funeral Director	al er	219-18-1025	ye street and number) FWS Ton Wedin Sex 15 M 20 F 7. Age (In yrs.	callent Glen	Prunder 24 Hrs. Hours Min.	8. Date of Birth	4c. County of Death ANN P 9. Birth Year) ANN ANN ANN ANN ANN ANN ANN ANN ANN A	Invalel
	Maryland -f show		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location RALTIMORE				10d. Inside City Limits 1 □Yes 2 ☑No
	vith the	Direct	10e. Street and Number		10f. Zip Code	257	10	0g. Citizen of What Cou	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Exam armust be Indiffied at Once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Wes 2 □ No If Yes, Give	If Yes, specify Cub		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
1215-0036	vithin 72 hou ne. han "natural n Medical E	Completed l	15. Decedent's Elementary/Secondary (0-12)	Education	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of work d)	ing	16b. Kind of Business/Ir	
Maryland 21	ould be filed v Mental Hygie arked other t atic event, in	To Be Co	17. Eather's Name (First, Middle, Las	URCA	Machinis	18. Mother's Nam	e (First, Middle, A	/ (01/10	
Mary	and 2 should balth and Mer n 27 Is marke ler traumatic		19a. Informant's Name/Relationship	(Type, Print) A. Son	19b. Mailing Address (Street	and Number or Run	E 2700 25		p Code)
lore,	Pages 1 annent of Healint: If Item 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State	Place of Disposition (Name of cemetery, crematory or other pla	201	Date	20c. Location - City or T BALTIMORE	
Baltimore,	permit. Page Department Important: If any injury or once.		4 □ Donation 5 □ Other (Special Signature 1 Sune 1 Style Lice	ense		ess of Facility Family Funeral H	ome And Crema	ation Center, P.A.	76(0)
			shock, or heart failure. List onl		th. Do not enter the mode of dyi	1 Mountain Roading, such as cardiac	- Fasaueria, No or respiratory arre	est,	Approximate Interval Between Onset and Death
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	Examiner	-e	Sequentially list conditions, cause. Enter Underlying	b. Due to or as a conseq	quence of):				
8760,	icate be executed physician and s the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq	quence of):				
.O. Box 687	death certific e attending pl id for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregni 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 Ectopic pregnand	у		23d. Date of delin	very Day Year
<u>a</u>	requires that the d een signed by the hould be detached	þ	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying cause g	ven in Part I.		pacco use contribute to es 2 □ No 3 □ Pro	
Il Records,	The law ate has b page 2 sl	Completed					24a. Was a autops perform	prior to c med? death?	topsy findings available ompletion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be (25. Was case referred to medical examiner?	Hospital: 1 Impatient 2	ER/Outpatient 3□ DOA	her	th (Check only on	e) ence 6 ∐Other (Spec	ufy)
Division of	dlng h. After fune	ertification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time of linjury 28c. Injury		28d. Describe ho	ow injury occurred	
Divis	Ital or Atten irs after deat ral Director: led in by the	Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		nome, farm, street, factory, office ify)		28f. Location (St City or Town	treet and Number or Ru n, State)	ral Route Number,
	Hosp 4 hou Fune iely fil	edical (Physician: To the best of my know aminer: On the basis of examina and manner stated.					
	To the within 2 To the complet	Me	29b. Signature and title of certifier			se number		9d. Date signed (Month	
,	18		30. Name and address of person wh	o completed cause of death (Ite	m 23a) (Type, Print)	053703 Glan Bus		Hargust 1.	2005
	V C	ate	Baltimor Was 31. Date filed (Month, Day, Year)	hington malic Registrar's Sign		Gen Bus	rie 1	MS	
	Regist		AUG 1 2 20	2. Registrar's Sign	ature fresh				

			State of Maryland / Dep		-	_
			. 101	ertificate of Death		26353
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
-	/Medic Examin	al	Anna F. Cimino 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August	8,2005 8:15PM M 4c. County of Death
		<u>. </u>	Oak Crest Care Center	Parkville		Baltimore
	Funeral Director		5. Social Security Number 194-01-1959 6. Sex 1 □ M 2 √ F 7. Age (In yrs. last birthda)	Months Days Hours Min.	8. Date of Birth (Month, Day April 28	9. Birthplace (State or Foreign Country) Pennsylvania
	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
	Maryli a-f sho	tor		timore		1 □ Yes 2 No
	with the	Direc	10e. Street and Number	10f. Zip Code 21234	10	Og. Citizen of What Country?
	ms 23	eral	8820 Walther Blvd. 11. Marital Status 12. Was Decedent Ever in U.S. 13	∠ I ∠ 3 ² / ₇ Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	U.S.A. 14. Race - American Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-f show amy injury or other traumatic svent, Ira Madical Examinational Le notified at once.	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Widowed 4 Divorced 1 Yes, Give 1 Yes, Give 1 Yes ar or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Black, White, etc. Specify: White
Maryland 21215-0036	notur	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	16b. Kind of Business/Industry
212	d withir giene. r than	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Own Home
פ	be filed tal Hyg d othe svent,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		
ızla	should be and Mental s marked o	은	Nicola Porcaro 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Marie		Cuviello City or Town, State, Zip Code)
	and 2 s ialth an 127 ls er trau		Robert Palumbi- Friend 920	4 Chenoak Court ba		
Baltimore,	iges 1 at of He if item or oth			ematory or other place)		20c. Location - City or Town, State
altin	mit. Pa bartmer cortant injury			d Memorial 8/12. 22. Name and Address of Facility Let		Baltimore, Maryland Ruck, Inc.
ă	Depar Impo any ir once.	W 7	I theather Count!	5305 Harford Road I	Baltimore	e,Maryland 21214
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	nter the mode of dying, such as cardiac	or respiratory arre	st, Approximate Interval Between Onset and Death
4	Examiner	_	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	LJieu		
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events	maluntitori		
760,	le be executed ysician and e burial-transit	cal Ex	resulting in death) Last Due to (or as a consequence of			
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P.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that is been signed by should be deta	d by Ph	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death?
Vital Records,	aw req 1s beer 2 shou	Completed			24a. Was ar	
<u> </u>	sicien: The law s certificate has b lirector, page 2 s	Com			perform	ned? death? 1 Yes 2 No
	sicien s certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Deat		a)nce 6 □Other (Specify)
n of	ng Phys fter this neral di	-	27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury 28b. Time (Month, Day Year)	-	28d. Describe ho	
Division of	or Attending Physicien: efter death. Director: After this certifice in by the funeral director. p	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home farm is	M 1 Yes 2 No	28f. Location (Str.	eet and Number or Rural Route Number,
<u>></u>	tal or A s effer et Dire ed in b	Certi	4 Homicide determined building, etc. (Specify)	area, rasiery, amac	City or Town	
	To the Hospital or Attending Physicien: The I within 24 hours either death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal continuous continuou	ath occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the ca red at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	29c. bicense number	29	dd. Dinte signed (Month, Day, Year)
	(0)		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) PAILON	e What	- 21234
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 2 2005 32 Jegistrar's Signature	pede		1

DHMH 17 Rev 1/2001

Anna Cimino

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** Gregory Allen Cook August 6. 20:07P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Carroll Westminster If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 18, 1955 **Funeral** 1☐M 2□ F Director 212-68-9221 50 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examinational be notified at MD Carroll Sykesville 1 No 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 516 Schoolhouse Road USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 XNever Married 2 Married ٥ 1☐ Yes 2☐XNo Specify: White ģ 3 Widowed 4 Divorced 'natural' Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Housekeeping Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any jiny or other traumatic event once. Melvin Marion Cook Mae Louise Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Wanda Cook (Sister) Schoolhouse Road Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) White Rock Cemetery 8/12/2005 Sykesville, MD 21. Signature of Funeral Service Licens PATGHT FUNERAL HOME & CHAPEL, PA (Box 195) Suan of the Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain Physician /Medical Examiner uv dio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? (1her 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HTN 2 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 ☐ Yes 2 ☐ ₩0 1 Inpatient 2 2 ER/Outpatient 3□ DOA

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Funeral Director: Af To the Funeral Director: Af

filed within 72 hours after death

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier Holain

5 Pending investigation

6 Could not be

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

who complet acause of death (Item 23a) (Type, Print) E Main St Westminster his

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Mon A.194) State Registrar

27. Manner of Death

1 Natural

2 Accident

3 🖺 Suicide

29a. Certifier

4 Homicide

Medical Certification:

32. Segistrar's Signature

MI)

28a. Date of Injury (Month, Day Year)

After

		1 - For State Registrar	State of Maryland	•	artment of H			iene .g. 12.00	15	26355
Physicia /Medic		1. Decedent's Name (First, Middle, Last	CARROLL				2. Date of Deat Month	th Day	Year 2005	3. Time of Death 4:45 A M
Examin		4a. Facility Name (If not institution, give	tospital			Allstou	2W	4c. County	Itim	
Funeral Director		5. Social Security Number 6. Se 215-30-0382 Usual Residence of Decedent	7. Åge (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birthp Cour M a	elace (State or Foreign aryland
a-f show	tor	10a. State 10b. County MD Baltim	10c. City, T		sor Mill				1	0d. Inside City Limits 1 ☐ Yes 2 No
3a or 28a	ii Direc	10e. Street and Number 17 Western Win		1110	10f. Zip Code 2 1 2		1	0g. Citizen of N		ntry?
f Health and Mental Hygiene. item 27 is marked other then "naturel", or Items 23a or 28a-1 show other treumatic event. If a Medical Exercit at marker notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 V Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:	- 1	Was Decedent of Hi If Yes, specify Cuba		Specify Yes or No- to Rican, etc.)	14. Rac Blac	ce - Americ ck, White,	
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Mental Hygiene. arked other then " atic event, Ir e Me	To Be Co	17. Father's Name (First, Middle, Last) William Crawl	еу		ore mane	18. Mother's Na	me <i>(First, Middle, I</i> ma Craw	Maiden Suman		
of Health and item 27 is ma		19a. Informant's Name/Relationship (T) Robin Carroll-E 20a. Method of Disposition	1 / Son 20b. Place	570	ng Address (Street and Field) Sition (Name of	iew Ct	., Balt		MD	21207
Department of Himportant: If ite any injury or of once.		1 Deurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licage	WOOC	llaw 22		ery 8	ylie F/		alt	MD imore Co MD 21133
ıysician Medical		23a Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	acations that caused the death. In the cause on each line. a. Due to (or as a consequent)	o not en	ter the mode of dyin	g, such as cardia	c or respiratory arr	est,		Approximate Interval Between Onset and Death
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by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3	Ectopic pregnancy Other (specify)				ite of deliver	ery Day Year
ite has been signed b page 2 should be deta	ρλ	Part II. Other significant conditions co	ntributing to death but not resultin	ng in the u	inderlying cause give	en in Part I.				he cause of death? pably 4 □Unknown
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		27. Manner of Death 1	28a. Date of Injury 28 (Month, Day Year)	b. Time o	Worl	yat k? Yes 2 □ No	28d. Describe h	ow injury occur	red	
olin b	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)				28f. Location (S City or Town	n, State)	·	
within 24 hours a To the Funerel I completely filled	ledical	one)	sician: To the best of my knowle iner: On the basis of examination and manner stated.	dge, deal and/or in	ivestigation, in my o	pinion, death occ	urred at the time, d	late and place,	and due t	the cause(s)
with To con	Σ	29b. Signature and title of certifier	youse D.	<i>'</i>	29c. Licens	e number 5564	4	Ped. Date signe August	ed (Month,	acos
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			For State	State of Maryland				Mental Hyg	giene	0 =	00000
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я	Physicia	an	John	R. Dumlei	<u> </u>			Month AUGU	Day ST 8, 6	Year = 2005	7:10 F M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4	4b. City, Town, or				y of Death	
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yla	should be nd Mental i marked o	2	John K. Du	uler, DR.	40h Maillean	Address (Carret	Mar	y rea	ley	Ctata Zin	Codo 2/23V
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	e death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of deat		Other (specify)			N	Month	Day Year
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sior	Attending Ph ir death. ector: After th by the funeral	catlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 []	Yes 2 □ No				
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À	14	I	30. Name and address of person who d	Omplete cause of death (Item 2	3a) (Type, P	D 47	W63		~ (• • (, ,	
4	UN		31. Date filed (Month, Day, Year)	M . D . 76.21 . DS 32. Registrar's Signatur	LERI	DRIVE T	OWSON	MARYLAN	D 212(24	
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5345	DANDER		For Unpend Item 23a,27,28a-1 pe					26357
	~		State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of I	Death	Reg. N	<u>.</u>	3. Time of Death
	Physicia /Medic		Valerie Darden			AUGUST 8	ay Year , 2005	0738 Ам
	Examin		4a. Facility Name (If not institution, give street and number) 911 N. FRANKLINTOWN ROAD		r Location of Death		c. County of Death	
1900	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. In 2 1	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Yea July 8, 19	62 Ma	olace (State or Foreign ntry)
	show			, Town or Location			1	10d. Inside City Limits 1 🕱 Yes 2 □ No
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Maryland	should nd Men marke umaric	으	19a. Informant's Name/Relationship (Type, Print) (Sister)	19b. Mailing Address (Street a	Anne Aumber or Rur.	al Route Number, City	or Town, State, Zip	Code)
	l and 2 fealth a m 27 le		Ms. Cynthia Mills	2317 Druic lace of Disposition (Name of	1. Hill +	Tre. Bat	to Ma. Location - City or To	2/2/7
mor	Pages 1 sent of h int: if ite iry or of		1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State	carnel —		-2005 F	3a Ho. 1	MA.
Baltimore,	permit. Departm importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address		uneral H	ome, P.A.	
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O. B	he deat the att	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown				Month	Day Year
s, P.O	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours elater death. To the Funaria Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of the funeral director, page 2 should be detached for use as the burial-transit of the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	þ	Part II. Other significant conditions contributing to death but not resu	Ilting in the underlying cause giv	en in Part I.		o use contribute to the	
cord	v requir been si should	eted	il .			1 ☐ Yes 24a. Was an		bably 4 Unknown
Rec	The lay	Completed				autopsy performed? 1 Yes 2	prior to co death?	mpletion of cause of
Vita	sician: certifica rector,	Be	25. Was case referred to medical examiner? 1 📈 Yes 2 🗆 No Hospital: 1 🗀 Inpatient 2	ER/Outpation 20 DOA Oth	105	h (Check only one)	a Province	SCENE
Division of Vital Records,	ng Phy fter this neral di	on: To		28b. Time of 28c. Injur	ry at rk?	ome 5 Residence 28d. Describe how in	41	77/
risio	Attendii death. ictor: A ly the fu	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At ho	me, farm, street, factory, office	Yes 2 X No	28f. Location (Street	and Number or Run	al Route Number. Franklintow
ρi	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifications of the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director dir		Scene			Rd., Balti	more, Md	
	ne Hosp 1 24 hou 1e Fune Hetely fi	Medical	23a. Certifier (Chack only one) 1 Certifying Physician: To the basis of my known one) 2 Medical Examiner: On the basis of examinal and manner stated.	wiedge, death occurred at the tir ion and/or investigation, in my c	ne, date and place, pinion, death occur	and due to the cause red at the time, date a	(s) and manner as s nd place, and due to	nateu. o the cause(s)
	withir To th	M	29b. Signature and title of certifier	29c. Licens			Date signed (Month, UST 8, 2	
0	IN		30. Name and address of person who completed cause of death (Item			1100		
7	1		ZABIUWAH AY	111 PENN STREE	T, BALTIM	ORE, MARYL	AND, 2120)1
	Sta · Registr		31. Date filed (Month, Day, Year) AUG 1 2 2UUD 32. Registrar's Sinna	ture				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8 Year DAVIES **Physician** ESTHER 05 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing Home Clinton Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 PA 6. Sex 5. Social Security Number Date of Birth (Month, Day, **Funeral** 1 M 2 F Months Days Hours 72-01-5136 Yrs. Director 93 Harrisburg Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show d other then "natural, or Items 23s or 28a-f sho event, the Nedicul Examinar must be notified at 1 ☐ Yes 2 ☐ No by Funeral Director MD Clinton Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7520 Surratts Road 20735 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give⁷ Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Importent: if Item 27 is marked other then "na any injury or other freumatic event, If a Neutle 2006. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chemical 12 Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samuel Lemon Mae Irene Eckerd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Richard Davies - Son 2001 Springvale Ct., Accokeek, MD 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 5, 2005 Alexnadria, Metropolitan * 4 □ Donation 5 □ Other (Specify) ²² Name and Address of Facility Cremation Service of Delaware 519 Philadelphia Pike, Wilm., 21. Signature of Funeral Service Licensee DE 19809 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscienti Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Live birth 2 ☐ Fetal death for Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at a be detached fo o. 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vemenna umers 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 2 Z No 1 Yes Division of Vital To Be 25. Was case referred to medical examiner?
1 \(\text{Yes} \) 2 \(\text{Yo} \) 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 / Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d, Describe how injury occurred 27 Manner of Death Medical Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death, hours after death, uneral Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral 6 To the Hospitel 1/ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Ornthe basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lvingston Rd Ft Washington mr Caine MD 11701 awhere 31. Date filed (Month, Day, Year) strar's Signature State 2 2005 Registrar

		4	For State Registrar	State of M		artment of H		and Mental Hy	giene Reg. 20	0.5	26359
			Registrar 1. Decedent's Name (First, Middle, Las	st)	001	incate or	Dealin	2. Date of De	ath		3. Time of Death
	Physicia	an	RONALD WILLI		JICH			AUGUST	$1^{Day}, 2$	0 0°5′	3:30pM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location o	of Death	4c. Coun	ity of Death	h
			727 S. GRUNDY				TIMOR			N/A	
	Funeral Director		5. Social Security Number 6. S 212-40-4946	ex 7. Ag M∑M 2□F	je (In yrs. last birthday) 63 Yrs.	Months Days	If Under:	Min. 8. Date of Bir (Month, Da	у. _{Уваг)} 19, 194	2. Birth Con	nplace (State or Foreign untry) ARYLAND
			Usual Residence of Decedent								^
	rylan thow	_	10a. State 10b. County		10c. City, Town or Lo						10d. Inside City Limits 1 X Yes 2 ☐ No
	8a-f s	ecto	MD. N/A		BALTI		-		10g. Citizen o	t What Co	
	with ti	Funeral Director	10e. Street and Number 727 S. GRUNDY	רחקקסתס		10f. Zip Code	224			.S.A	
	Jeath Ins 23	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13.			gin? (Specify Yes or No i, Puerto Rican, etc.)		ace - Ame	ncan Indian,
9	72 hours after death with the Maryland natural', or Items 23a or 28a-f show lical Examiner must be notified at	Fun	1 Never Married 2 Married	Armed Forces? 1 XYes 2 ☐ If Yes, Give	No	If Yes, specify Cubin 1 ☐ Yes 2X No	an, Mexican Specify:	i, Puerto Hican, etc.)	Spec	lack, White	
903	nours Jrail,	d by	3 Widowed 4 Divorced	Year or Dates:	1960-66					W	HITE
15	n 72 h "nati	lete	15. Decedent's Ed (Specify only highest gra	ide completed)	(Give	deni's Usual Occup kind of work done DO NOT use retire	during most	t of working	16b. Kind of	DUSINGSSA	industry
21215-0036	i within jiene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or	TEC	CHNICIAN	I .		NORTH	ROP (GRUMMAN
	al Hygie d other vent, t	Be C	17. Father's Name (First, Middle, Last)					er's Name (First, Middle			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiens. I Health and Mental Hygiens than "natural", or thems 23a or 28a-f show item 27 is marked other than "natural", or thems 23a or 28a-f show item 27 is marked other than "natural" or the Medical Examinar must be notified at	2		LICH				HEODORA	WAZIN		Zin Codo)
Mar	12 sh hand 7 is m traum		19a. Informant's Name/Relationship (ELSIE ENDLICH/					er or Rural Route Numb TREET , BAL			
	ges 1 and to 6 Health If item 27 or othar tr		20a. Method of Disposition		20b. Place of Disp		- !	Date	20c. Location		
ē	00		1 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Removal from State b)	1 1			8/13/05	BALTI	MORE	, MARYLAND
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licer	1588		Name and Addre	ŽEIL ONKL	ER INC. F ING STREE	UNERAL	L HO	ME MD. 21224
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death. Do not en						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			low-Sm	4116	ELL LUN	G CHL	Kel	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of):	1 1	1	ELL LUN			1121
	LXdiiiiici	_	Sequentially list conditions,	b. Houte	a consequence of):	/ FAI.	IUre				WK
	uted d ansit	m L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that inilieted events	Hupe	rtensio	لر					4R
oʻ	certificate be executed rding physician and use as the burial-transit	Physician/Medical Examiner	resulting in death) Last	Due to (or as	s a consequence of):						
8760,	# × #	dical		d							
9 X	leath certifica attending ph d for use as th	/Med	IF FEMALE:	23c. If yes, outcome	e of pregnancy				23d. l	Date of del	liverv
Box	that tha death cer ad by the attendin detached for use	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	У			Month	Day Year
P.O.	t tha c by the tacher	hys	9 Unknown	9 Unknown						-	
Records, F	iaw requires that tha death as been signad by the atter 2 should be detached for u	Completed by P	Part II. Dther significent conditions of CUMDWI		but not resulting in the	underlying cause gr	ven in Part I		tobacco use co Yes 2□No		o the cause of death? Tobably 4 Anknown
00	s beer s shou	olete						24a. Was		b. Were au	utopsy findings available completion of cause of
	Tha lay	mo						perf 1 ☐ Yes	ormed?	death? 1 🔲 Yes	-
Vital	yslcian: Tha is certificate ha	Be	25. Was case referred to medical examiner?			2		e of Death Check on	one		
of V	Physician: this certific ral director,	²	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpat 28a. Date of In		IN 3 DOA		ursing Home 5 Res 28d. Describe			cify)
on	ffer fre	tlon	1 Natural 5 ☐ Pending	(Month, D	ay Year) Injury	Wo	ork?]Yes 2 □		now injury oo		
Division	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined		njury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location	(Street and Nu	m <i>ber</i> or Ri	ural Route Number,
Ö	rs afte al Dire ed in l	Cert	4 - Hotticide	building, e	otc. (Specify)			3.7 57 73	, 0.2.07		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Pi (Check only 2 Medical Exa	miner: On the basis	of examination and/or i	nvestigation, in my	opinion, dea	nd place, and due to the ath occurred at the time	, date and plac	ce, and due	e to the cause(s)
	Vithir To th comp	M	29b. Signature and title of contifier	1 /	10	29c. Licen	se number	7/10	29d. Date sig	ned (Mont	th, Day, Year)
	1.4		Cellen	Rec	ces "	D	ング	177	Stug	UST	11,2005
	1041		30 Name and address of person who AllEN Reilly,	completed cause of 46	death (Irem 23a) (Type	g Cross	Roa	ed, Baltin	nore #	MD.	th, Day, Year) 11, 2005 21228
	St Regist	ate rar	31. Dale filed (Month, Day, Year) AUG 1 2	2005 32. Regis	Irar's Signature	foods					

			1 - State Registrar		artment of Health and M rtificate of Death		005 26360
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death
	/Medic Examin		Harry Falls 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital		4b. City, Town, or Location of Death Frederick	August	9,2005 2:00 A M 4c. County of Death Frederick
	Funeral Director	-1	5. Social Security Number 6. Sex 7. Age (In 215-32-6393 Usual Residence of Decedent	yrs. last birthday) 2 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y June 28,	9. Birthplace (State or Foreign Country) Baltimore, MD
poels	Mot H		10a. State 10b. County 10	c. City, Town or Lo			10d. Inside City Limits
N a	8e-f st	ctor	MD Frederick	Fr	ederick		1 ☐ Yes 2 🔀 No
th with	23a or 2	Funeral Director	5955 Quinn Orchard Road		10f. Zip Code 21704		p. Citizen of What Country? USA
5-0036 72 hours after death with the Maryland	you said the said of the said	d by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
1215-0 within 72 h	ene. then "natu	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) ministrator	ing	b. Kind of Business/Industry Housing Authority
Maryland 21215-0036	hental Hygirked other	To Be Co	17. Father's Name (First, Middle, Last) Burford Falls		18. Mother's Name	(First, Middle, Ma	15 miles 1 mil
4 5	alth and M	-	19a. Informant's Name/Relationship (Type, Print) Donna Tocco /Daughter		ng Address (Street and Number or Rura 37 Black Forest W		
Baltimore,	in the second		1 Deniet of Commetice of The Comment of Comments	Ob. Place of Dispo cemetery, cren Butler Cou	natory or other place) Auc	one 13, 20 (10) (10) (10) (10) (10) (10) (10) (10	c. Location - City or Town, State Butler, PA
Balti	Depart Import any in		21. Signature of Poneral Service Licensee	22	Name and Address of Facility Charles L. Stevens F 1501 Fast Fort Ave B		
E	hysician /Medical xaminer	niner	resulting in death)	Imonia nsequence of):	er the mode of dying, such as cardiac (or respiratory arrest	Approximate Interval Between Onset and Death
I Records, P.O. Box 68760, The law requires that the death certificate be executed	physician and as the burial-transit	edicai Examiner	that initiated events c. Due to (or as a co	nsequence of):			
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rds, P.	been signed I	ed by P	Part II. Other significant conditions contributing to death but no	t resulting in the un	nderlying cause given in Part I.	23e. Did tobad	cco use contribute to the cause of death? 21 No 3 Probably 4 Unknown
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of Vital	certific rector.	o Be	25. Was case referred to medical examiner? Hospital:		Othor	(Check only one)	
ion of	After fune	H-	1 Yes 2 No Inpatient 27. Manner of leath 1 Natural 5 Pending 2 Accident investigation 1 Inpatient 28a. Date of Injury (Month, Day Yei	2 ER/Outpatien 28b. Time of Injury	1 3 DOA 4 Nursing Ho	me 5 🗌 Residend 28d. Describe how	ee 6 Other (Specify) injury occurred
Division tel or Attending	s after de el Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S	At home, farm, stro oecify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Division Division	within 24 hours after death To the Funerel Director: completely filled in by the	Medicai (29a. Certifier (Check only one) Certifying Physician: To the best of my and manner stated.	/ knowledge, death mination and/or inv	occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the caus red at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
101	with To 1	2	29b. Signature and vitle of certifier Shah Hi	ron, mo	29c. License number D 5764 3	29d.	Date signed (Month, Day, Year)
- 4	P		30. Name and address of person who completed cause of death 55 Thom 43 31. Date filed (Month, Day, Year) 32. Registrated	Thomson	7	dends	mg 2/702
	Sta Registr	ar	AUG 1 2 ZUU5	S. Span	W		

Arthur Fedeli 05-05419 NJM

Baltimore, Maryland 21215-0036

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		1 _ State	State of Maryland		artment of h			neg. Ng)		20001	
		Ragistrar 1. Decedent's Name (First, Middle, Last)			timodio or i		2. Date of Dea	th	000	3. Time of Death	
Physicia /Medic		Arthur F. F	edeli, Jr.				August	extstyle e) 200	05 1715 ^M	
Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Deat	n	4c. C	4c. County of Death		
		Union Memorial Ho	<u> </u>		Baltim	IOTE	1.5.5.4.5.4		N/A		
Funeral Director		218-30-5452	7. Age (In yrs. /as	Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Da)	r, Year)	C	rthplace (State or Foreign Jountry) aryland	
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits	
Mary	to	Md. Baltim	ore		Luther	ville				1 ☐ Yes 2X No	
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?			
ath w	rait	712 Chapel Ridge				1093		USA			
er de	Funeral	11. Marital Status 1 Never Married 2 Married	 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo 	13.	. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			1	 Race - Ame Black, Whi 		
filed within 72 hours after death with the Maryland Hygiene. sther than "neturel", or Itema 23a or 28a-1 ehow ent, the Madical Examinar must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:		3	Specify:	White	
72 ho	Completed	15. Decedent's Education (Specify only highest grade	ation completed)	16a. Deced	dent's Usual Occupa	ation during most of wo	rkina	16b. Kin	d of Business	s/Industry	
Aithin Ne.	шbі	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	n)			Constr	wetien	
illed v Hygie ther t nt, th	e Co	17. Father's Name (First, Middle, Last)		GELIE.	ral Contr		ne (First, Middle,			CC CTOH	
d be ental ked o c eve	To Be	Arthur F. F	edeli Sr			Ka	therine	Mi11	er		
shoul ind M ind M umari	-	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street					Zip Code)	
and 2 alth a 127 to er tre		Mrs. Patricia L. Fe	deli/Wife	712	Chapel Ri	dge Road		vill	e, Mar	yland 21093	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 te marked other than "neturel", or Itema 23a or 28a-f ehow any injury or other treumatic event, the Madical Examiner must be notified at one.		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	netery, crer	sition (Name of matory or other plac		Date		cation - City or		
it. Pa ortmer ortant njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licepset		ney Va	alley Mem	s of Facility D.	/15/05	Timo	nium,	Maryland	
Depertment of the population o		mila	Durch		050 York		wson, Ma			Home, Inc.	
		23a. Part1. Enter the disease, or emplicion shock, or heart failure. List only one	ations that caused the death.						na ziz	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	Atherosclero							Onset and Death	
/Medical		resulting in death)	Due to (or as a conseque								
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the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	5							
law requires thet the death certificate as been signed by the attending phys r 2 should be detached for use as the	by PI	Part II. Other significant conditions conf	nbuting to death but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco us	e contribute t	to the cause of death?	
w require been sig should b	ed			-			101	∕es 2□]No 3□P	Probably 4 □Unknown	
law re las be	Completed						24a. Was autop	sy	prior to	autopsy findings available completion of cause of	
sicien: The law s certificate has t irector, page 2 s	Con						perio 1 ☐ Yes	med? No	death? 1 ☐ Ye	s 2 No	
sicien certifi rector	Be	25. Was case referred to medical examiner?	ospitat	2/0	Oth	or.	ath (Check only o		- Flow (0		
Physicie ar this cert eral direct	D: To	1X Yes 2 No 27. Manner of Death	28a. Date of Injury 2	R/Outpatier 8b. Time o	II 3LI DOA	4 🗆 Nursing i	10me 5 Resident			эсіту)	
nding l ath. r: After ie funer	atio	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Yes 2 ☐ No					
or Attending Physicien: ifier death. Director: Atter this certific In by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, sti	reet, factory, office		28f. Location (S City or Tox		Number or F	Rural Route Number,	
urs af arai D		200 Continu				data and also					
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only one) A Medical Examin	 ician: To the best of my know or: On the basis of examination and manner stated. 	n and/or in	n occurred at the tir evestigation, in my o	pinion, death occ	urred at the time,	date and	and manner a place, and du	is stated. Je to the cause(s)	
within 2 within 2 To the comple	×	29b. Signature and title of certifier	^		29c. Licens	e number		29d. Date	signed (Mon	nth, Day, Year)	
		John	1)		OCI	Œ		Aug	ust, 1	.1, 2005	
		30. Name and address of person who cor	mpleted cause of death (ttem 2	23a) (Type,	Print)	nn Stree	et Balti	more	. Marv	land 21201	
	10	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re /					,		
Sta Registr		AUC 1 9 2005	Received B.	GOB4							

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 11 per inf 8-31,05 the Amend item 11 Meryland Department of Health and Mental Hygiene State Unpend Item 23a,27,28a-f per me 6346,8-16-05 tas Registrar amend item/1, perME, G846,8/12/05/21e of Death Reg. No.2005 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 05, 2005 3:40a Erica Kaplan Farrell AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY JOHN HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 TF 09/18/1980 Director 122-70-7720 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 23a or 28a-f ehow ir than "natural", or items 23a or 28a-f ehor the Medical Examinar must be notified at 1 Yes 2 No Directo Baltimore City Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21231 103 S. Ann Street death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after To Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mortgage College (1-4or 5+) Elementary/Secondary (0-12) Sales Ith and Mental Hygie 27 Is marked other r traumatic event, other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 9DCB. Be Robert Thomas Farrell Nancy Kaplan 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Kaplan / mother 20-A Tree Farm Court Glen Arm, MD 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug 6 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc. 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Drive Baltimore, Maryland 21286 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Mixed Drug(Methadone, Diazepam, Diphenhydramine) Intoxication **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 use as the attending to to use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 \(\text{Yes} \) 2 \(\text{No} \) 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \(\subseteq \text{No} \) page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?

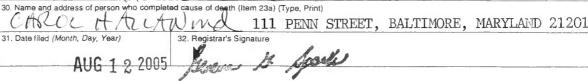
1/□ Yes 2 □ No Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 💢 ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this After thi 28a. Date of Injury Fo(Month, Day Year) 5-05 27. Manner of Death 28b. Time of unk 28c. Injury at Work? 28d. Describe how injury occurred Found, AM 1 Natural 5 Pending To the Hospital or Attendin within 24 hours efter death.

To the Funeral Director: Af Completely tilled in by the turn s efter death. 1 ☐ Yes 2 No investigation 2 Accident 6 X Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Sumber, City or Town, State) 103 S. Ann St., Baltimore, MD determined 4 Homicide Baltimore, Found in residence 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME AUGUST 05, 2005

State

31. Date filed (Month, Day, Year)



Registrar

				partment of Health and M		2000 2000							
_			Registrar	ertificate of Death	Reg. f								
	Physicia	an	1. Decedent's Name (First, Middle, Last) The LMA GREEN		Date of Death Month	Day Year 3. Time of Death							
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	8	7 2005 45tm							
	Examin	er		Baltimore		40. Oddity of Death							
	Funeral		Bon Secour Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign							
	Director		214-22-3465 1 M 2 M F 82 Yrs.	Months Days Hours Min.	(Month, Day, Yea 04 14	2.3 MD							
-	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or										
	farylan show	5	MD NA Baltin			10d. Inside City Limits 1 ★Yes 2 No							
	the N	Director	10s. Street and Number	10f. Zip Code	100.0	Citizen of What Country?							
	with Se or	Ö		100 11 200	109.								
	ms 2	Funerai	2440 Lauretta Ave 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21223 . Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	U • S • A • 14. Race - American Indian,							
9	or Iter		Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.							
93	ours ral', c	d by	Myvidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black							
21215-0036	within 72 hours after death with the Maryland ene. Then "natural", or liems 23e or 28e-f show na Madical Examinar must be motified at	Completed by	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (G.	edent's Usual Occupation re kind of work done during most of worki . DO NOT use retired)	in <i>g</i> 16b.	Kind of Business/Industry							
121	withir ane. then	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker		House							
d 2	filed withi Hygiene. other then		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid								
lan	ld be ental ked c	To Be	Samuel McCray	Oueeni	e Hamilt	on							
Maryland	2 should be f and Mental i le marked of eumatic eve	-		iling Address (Street and Number or Rura									
	s 1 and 2 should be filed within 72 hours after death with the Maryla f Heath and Mental Hygiens 1. The 21 is marked other then "natural", or Items 23e or 28e-f show then treumatic event. It a Maxical Examination using the rediffied at		Mildred Barnes-Daughter 750	7 Heatherfield	Dr, Balt	imore, 21244							
altimore,		1	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Discemetery, completely, complete	position (Name of pematory or other place)	Date 20c.	Location - City or Town, State							
Ë	t. Pa rtmen rtent:		`4 □Donation 5 □Other (Specify) Marylar	d National 8/12	/05 L	aurel, Md							
Balt	permit. Depart Import eny in		21. Signature of Funeral Service Licensee	, ~									
	συ = • α	_	Wille Edmond	March F/H West 4300 Wabash Ave									
			23a. Part1. Enter the disease, or complications that caused the death. Do not on shock, or heart failure. List only one cause on each line.	Manager or dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death							
	Physician /Medical		issesse or condition resulting in death) Due to (or as a consequence of):										
	Examiner		Due to (or as a consequence or):	1 Artery	Dege	.00							
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Ö,	e exe ian al urial-t	Ex	resulting in death) Last Due to (or as a consequence of):										
8760,	cate be executed physician and the burial-transit	dlcal	d										
9	ding page as	0	IF FEMALE: 23c. If yes, outcome of pregnancy										
Вох	death certifii attending p	Physician/M	in the past 12 months?	□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year							
P.O.	that the de led by the a detached t	ysic	1 Yes 2 No 9 Unknown 9 Unknown										
S, D	The law requires that the death certif tie has been signed by the attending page 2 should be detached for use as	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?							
rds	v requires been sig should be	q pe	my pertension		1 🗆 Yes	2 No 3 Probably 4 Waxhown							
Record	aw requis been 2 should	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of							
H		mo			performed?	death?							
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		(Check only one)								
of \	Physicien: this certificatal director,	2	1 ☐ Yes 22 10 Hospital: 1 ☐ Inpatient 2 DEN/Outpat			6 ☐Other (Specify)							
		ion	27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time (Injury)		28d. Describe how in	jury occurred							
Division	vttendii death. ctor: A ctor: A y the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		28f. Location (Street	and Number or Rural Route Number.							
Div	after after I Dire	Certification;	4 Homicide determined building, etc. (Specify)	and the state of t	City or Town, Sta								
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 ertifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the cause	(s) and manner as stated.							
	he Ho in 24 the Fu	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)							
	With To t	Σ	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)							
•			Parul Colour M	1 1000178		17/2005							
	3		30. Name and address of person who completed cause of death (Item 23a) (Typ	EALLS RA	BAI -	10MP 21211							
•••	Sta	- 3	31. Date filed (Month, Day, Year) AUG 1 2 2005	.00	· · ·								
5	Registr	ar	HOW I S 2003 Stephen Son Page										

			State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. 2005 26364	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death	1
	Physici	an	Pacifical (-1.1/6)	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	Examin	er	Franklin Square Huspital Rosedale Baltimore	
	Funeral			ign
	Director	9	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 9. Birthplace (State or Fore Country) 9. Birthplace (State or Fore Country) 9. WestVirgin	ia
	p s		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	its
	Maryla 1 sho	ō	mo Baltimore 21221-ESSEX 10 Yes 2981	
	28a-	Director	10e Street and Number	
	ours after death with the Marylan ral', or Itams 23a or 28a-1 show Exam nat must be notified at	Ö	358 Upper Landing Road 21221 U.S.	
	death ms 2	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
9	or Its	Fu	1 □ Never Married 2 Married 1 □ Yes 2 1 No 1 □ Yes 2 No Specify: Specify: Specify: 1 □ Yes 2 No Specify: 1	
21215-0036	within 72 hours after death with the Maryland one. than "natural", or Itams 23a or 28a-1 show the M. ofcal Exemt for Lital Le. notified at	d by	3 Wildowed 4 Divorced Year or Dates:	
15	"nat	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
12	withi iene. than	mo	Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager Duronn Paints	
	Hygie other	Be C	12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
<u> a</u>	ould be filed with Mental Hygiene. arkad other than atic event, the	To B	Avery F. Gulley Nellie Locke	
Maryland	and and Is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	1 and 2 Health Iam 27 othar tra		SAndra Gulley /wife 358 Upperlanding Road Balto.MD 20a. Method of Disposition (Name of Date 20c. Location - City or Town, State	
0	0 0		1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery, crematory or other place)	
altimore,			4 Donation 5 Other (Specify) OakLawnCemetery 8/16/05 Baltimore MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility	_
Ba	permit. Departr Imports any Inju		ConnellyFuneralHomeofEsse	x
	-		23a. Part1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 300 MACE Ave. Baltimore MD 21221 Approximate interval Between	
	Physician		Unset and Death	
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	
H.	Examiner		Sequentially list conditions b.	
/	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	
	and -trans	Examiner	Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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687	ficate physics the	edlcai	d.	
Вох	leath certifica attending ph d for use as t	Z	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of delivery	
	death	sicia	1 Pregnant at time of death 5 Other (specify)	
P.0	that the de ted by the a detached	Physician/Me	9 Durknown	
	p o	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	wn
Records,	w requir been si should	Completed		
Sec	siclan: The law certificate has b irector, page 2 s	mpl	24a. Was an autopsy findings availat prior to completion of cause of death?	of
Vital		e Co	1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)	
>	Physiclan: this certific ral director.	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
J of			27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
ior	Attanding or death. actor: After by the fune	atio	2 Accident investigation M 1 Yes 2 No	
Division	or Att	Certification:	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	pital ours all		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
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	To the To the Comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
			D18358 08/11/2005	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shipdon Milner Mo 9110 Philadelphia Ra (21237)	
	12		Shiden Milver, MD 9/10/hiladelphia Rd (21731) 31. Date filed (Month, Day, Year) \$32. Registrar's Signature	
	Sta Registi		AUG 1 2 2005 AUG 1 2 2005	

Golley, Reginald

			1 - For State Registrer	State of Maryland		artment of F		Re	g. NZ U U 5	26365
	Physici /Medio		1. Decedent's Name (First, Middle,	SUILLIAM S	S			2. Date of Death Month	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution,	give street and number)		_	r Location of Death		4c. County of Dea	ath
				SICAL CENT			MORE,	MD		
	Funeral Director		5. Social Security Number 288-58-5226 Usual Residence of Decedent	6. Sex 1 M 20 F 7. Age (In yrs. It	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		nthplace (State or Foreign ountry) hio
	yland		10a. State 10b. County	10c. City	, Town or La	cation				10d. Inside City Limits
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	or 26	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23e		P.O. Box 295	10 Was Dandard Constant	2 10	2685			U.S.A.	
36	d within 72 hours after death with the Maryland piene. I then "natural", or Items 23e or 28e-1 show the Medical Examination must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	1	was Decedent of H fYes, specify Cuba 1 ☐ Yes 2 🟋 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Am Black, Whi Specify:	ite, etc.
21215-0036	72 hou natura dical E	ted	15. Decedent's	Education		dent's Usual Occup		1	6b. Kind of Business	White
215	within 7. iene. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give life. l	kind of work done of DO NOT use retired	during most of work d)	ring		,
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3	2 should be and Mental Is markad o	To	Joseph Kelly 19a. Informant's Name/Relationshi	n /Typa Printl	10h Mailie	an Address (Ctrost			erson Kel	•
Ma		1	John A. Guilli				Rurgitts		City or Town, State,	Zip Code)
ē,	s 1 and 2 if Health Item 27 I	1	20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of			0c. Location - City or	Town, State
altimore,	Pages nent of int; if it		1 🎇 Burial 2 □ Cremation : 1 4 □ Donation 5 □ Other (Spe			natory or other plac emetery	8/12	2/05	Moorefiel	d. WV
alti	permit. Pages Department of Importent: If II any Injury or conce.	i	21. Signature of Funeral Service Li		22	. Name and Addres	ss of Facility			,
8	89 = 88		Dennes (Hellmin		217 Winch		., Moore	field, WV	26836
	Physician /Medical		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death
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O. Box	D 0 D	Physician/Medicai	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Onknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
Δ.	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition	s contributing to death but not resu	Iting in the ur	nderlying cause give	en in Part I.	23e. Did toba	icco use contribute to	o the cause of death?
rds	v requires been sign should be	ed b	END STAGE	E KENAL		SEAS	E	1 🗆 Yes	2 □ No 3 □ P	robably 4 Unknown
Vital Records,	ie faw requ has been je 2 shouli	Completed by	MORBID (BESITY				24a. Was an	24b. Were a	utopsy findings available completion of cause of
Œ E	The ate his page	Com	DIABETE	S MELLIT	rus			autopsy performe	ed? death?	
/ita	iclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					h (Check only one,)	_
of		10	1 Yes No	The second secon	R/Outpatien		4 Nursing Ho		ice 6 Other (Spe	ocity)
u _Q	ding After fune	tion	27. Manner of Death Natural 5 Pending investiga	(Month, Day Year)	28b. Time of Injury	28c. Injury Work	/ at <br Yes 2 □ No	28d. Describe how	/ injury occurred	
Division	I or Attanding after death. Director: Aftel I in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could no	t be One Blace of lains, At her	me, farm, stre		192 5 140	28f. Location (Stre	et and Number or Ri	ural Route Number
<u>S</u>	al or A after 1 Direct	erti	4 Homicide	building, etc. (Specify)		,,,		City or Town,	State)	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edicai C	29a. Certifier Certifying (Check only one)	Physician: To the best of my know ceminer: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the tim restigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and manner as e and place, and due	s stated. e to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Mont	h, Day, Year)
)			KREDU	Olakia 1	D	DOO	6332	6 8	3/8/04	_
	h		30. Name and address of person w	no completed cause of death (Item	23a) (Type, I	Print)			1 10	
	/		KUSH . DHO!	AKIA. MD	MER	RCY ME	EDICAL	. CEN	TER, BA	LTIMORE MD
	Sta Registr	14	31. Date filed (Month, Day, Year) AUG 1 2	32 degistrar's Signatu	e do	we			,	

			1 - For State of Maryland / Department Certification		glene
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) NORMA A GENTILE As Equilibritian of the street and purples.	2. Date of De. Month A LL 9	Day 11 Year 5 1040 AM
	Examin	er		3ALTIMORE	4c. County of Death BALTIMORE
	Funeral Director		5. Social Security Number 220-22-/054 1 M 2 F 7. Age (In yrs. last birthday) Wonth Usual Residence of Decedent	der 1 Year If Under 24 Hrs. 8. Date of Bin (Mogth, Da	y, Year) Country)
	e Maryland 8e-f show liffed at	ctor	10a. State 10b. County 10c. City, Town or Location Baltimore Baltir	nore	10d. Inside City Limits 1 □ Yes 2 🗗 10
	with th	i Dire	10e. Street and Number 1529 Vesper Rd	Zip Code 2 / 2-2-2	10g. Citizen of What Country?
936	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 Is marked other than "naturelt, or Items 23a or 28e-f show titem 27 is marked other than "naturelt be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Never Married} \) 2 Married 1 \(\text{Never Married} \) 1 \(\text{Never Married} \) 1 \(\text{Never Married} \) 1 \(\text{Never Married} \) 1 \(\text{Never Married} \) 1 \(\text{Never Married} \) 1 \(\text{Never Married} \) 1 \(\text{Never Married} \) 1 \(\text{Never Married} \) 1 \(\text{Never Married} \) 11 \(\text{Never Married} \) 11 \(\text{Never Married} \) 12 \(\text{Never Married} \) 11 \(\text{Never Married} \) 12 \(\text{Never Married} \) 12 \(\text{Never Married} \) 11 \(\text{Never Married} \) 12 \(\text{Never Married} \) 13 \(\text{Never Married} \) 1	cedent of Hispanic Origin? (Specify Yes or No pecify Cuban, Mexican, Puerto Rican, etc.)	
21215-0036	filed within 72 hou Hygiene. ther then "nature int, he Wedical E	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	work done during most of working	16b. Kind of Business/Industry OWN Home
Maryland 2	ould be filed Mental Hygi arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) GUS ERAF	18. Mother's Name (First, Middle, Ruth Mon	
	1 and 2 sho Health and Sem 27 Is my		William Gentile-Husband 1529 V 20a. Method of Disposition (1	ass (Street and Number or Rural Route Number of Park Rd Patho	er, City or Town, State, Zip Code) 20c. Location - City or Town, State
altimore,	Page nent o ant: If ury or		1 Burial 2 Peremation 3 Removal from State 1 Donation 5 Other (Specify)	me facel Aug 12 2ms	Baltmare mi
Ball	permit. Pag Department Importent: I eny Injury o once.		21. Signature of Funeral Service Licenses 22. Name 23. Name 24. 344	and Address of Facility A LEY- ASH TON FUNCTION WILLIAM SALIDAR RO	al Home, P.A.
3	Prysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ode of dying, such as cardiac or respiratory and	rrest, Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):		
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and to age 2 should be detached for use as the burial-transit.	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (o as a consequence of): c. Due to (or as a consequence of):		
9	entificate I	/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		
.O. Box	that the death certific: ed by the attending pl detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other		23d. Date of delivery Month Day Year
ords, P	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying DEPRESSION S P STROKE	g cause given in Part I. 23e. Did to	obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Il Records,		Completed by		24a. Was autop perfo 1 □ Yes	
Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpatient 3	26. Place of Death (Check only of DOA) Other: Nursing Home 5 ☐ Resident	
Division of	ling After une	Certification: 7	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident 28a. Date of Injury (Month, Day Year) Accident Natural S Natural Injury (Month, Day Year) M		now injury occurred
Divis	i Hiti	Sertific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	ory, office 28f. Location (S City or Tow	Street and Number or Rural Route Number, vn, State)
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurr on the basis of examination and/or investigation and manner stated.	ed at the time, date and place, and due to the on, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within To the comple	Me			29d. Date signed (Month, Day, Year)
•	ix		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D56705	August 11th, 2005
	10		RACHELLE GAJADUAR, 5505 HOPKINS BAY	HEW CIRCLE, BALTIN	10RE MD 21224
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 2 2005 AUG 1 2 2005	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Month rimona 50AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Toyn, or Location of Death 4c. County of Death **Examiner** Reusin Har goods DACTIMORE 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 218-18-4007 Yrs. Director Usual Residence of Decedent illed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at MD 1 Yes 2 □ No PACTIMORE Director 10e. Street and Number 10g. Citizen of What Country? U.S.A. or Items 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 □ No 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married DLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced Year or Dates "natural", 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) if Health and Mental Hygiene. Item 27 is marked other then College (1-4or 5+) FOREMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental ? 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BATIMORE MAYLAND 212/8
ate 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of H Important: If Ite any injury or ot 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 8.14.05 OWINGS MILLS, MARYLAND tox151 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VANGHIN C. CIKEENE FUNERM Home 21. Signature of Funeral Service Licensee Var Irane ROAD BALTIMOKE, MAKYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Local Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit melerous Due to (or as a consequence of): P.O. Box 68760, use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy detached for Month Dav Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 s has autopsy performed? Yes 200 No certificate 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 M ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending Injury 1 🗌 Yes within 24 hours after death. To the Funeral Director: Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) ro the 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) secracio 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Bultinuste 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#3,23a,perMD,G846,8-26-05 11

State of Maryland / Department of Health and Mental Hygiene

1- For Amend Item 20b per fh G846 8-19-05 tas
Reg. N2 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 **Physician** Robert Walter Ginnis August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14129 Eternity Road Germantown Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 12, 1927 Country) Michigan Months 1 M 2 □ F 386-22**-**0527 77 Director December Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 27 Is marked other than "natural", or Items 23a or 28e-f show traumetic event, Ite Medical Examinational be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 20874 14129 Eternity Road United States death Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status e filed within 72 hours after all Hygiene. I Hygiene. I other then "natural", or Itel 1 X Yes 2 No If Yes, Give TZ 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Korea þ 3 Widowed 4 Divorced ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) <u>=</u> Compl Elementary/Secondary (0-12) College (1-4or 5+) University of Business Manager Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fit of Health and Mental H fitem 27 Is marked oth Be Helen Holtzman Walter Ginnis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14129 Eternity Road, Germantown, Maryland 20874 Constance M. Ginnis/ Wife 20b. Place of Disposition (Name of commetery, crematory or other place)
Arlington National Cemetery 20c. Location - City or Town, State 20a. Method of Disposition October permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, Virginia `4 ☐ Donation 5 ☐ Other (Specify) 24, 2005 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue M01433Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Lung Gancer Metastatic Bladder Cancer Immediate Cause (Final Months Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy requires that the death Month Day Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 8 1 Yes 2 No 3X Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 1 Yes 2X No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 ☐ Yes 2 X No funeral dir this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P after death. I Director: After I Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of August 12, 2005 D18219 ULI 30. Name and address of person who completed cause of death (from 28a) (Type, Print) Leon Hwang, M.D. 1396 Piccard Drive, Rockville, Maryland 20850 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra AUG 1 2 ZUU5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year MARVIN GREEN 2000 August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BALTIMORE UNIVERSITY OF MORYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Days Hours **½** M 2 □ F 212-78-6130 44 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits XY Yes 2 No Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3035 Seamon Avenue 21225 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marion Green Ernestine Marion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernestine Green/mother 3035 Seamon Ave., Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 8/12/2005 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licenses Juneda Vanas 638 N. Gilmor St., Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (dr as a consequence of): CRI Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€No 1 ∠ npatient 2 □ ER/Outpatient 3 DOA

Physician /Medical **Examiner** To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

attending pl

After

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If Item 27 is marked other tt any injury or other traumatic event, I'lla once.

Physician

/Medical

Examiner

10a. State

Funeral

Director

r than "natural", or Items 23a or 28e-f show the Medical Examinar must be redified at

Be Completed by Funeral Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

Division of Vital

Examiner physician and the burial-transit

Completed by Physician/Medical Be 2

27. Manner of Death Certification:

1 ANatural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

vithin 24 hours after death. To the Funeral Director: A	y filled in by the I	
within 24 To the Fu	completely	
	1	

State Registrar 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

MD

28a. Date of Injury (Month, Day Year)

29c. License number

Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

7657

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOLUTH GREENE STREET BACTIMORE MARYLAND Rebecca Manno, MD

31. Date filed (Month, Day, Year) AUG 1 2 2005

32. Registrar's Signature

28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of			jiene eg. No)	005	26370
	Physici	an	1. Decedent's Name (First, Middle, La.	st)				2. Date of Dea	Day	_ Year	3. Time of Death
	/Medi		Donald George					July	3)	2005	11:30AM
7	Examir	ner	4a. Facility Name (If not institution, give				r Location of Death	,	4c. Co	ounty of Death	
			5. Social Security Number 6. S	ALLTY HO	05 P e (In yrs. last birthda)		IMORE If Under 24 Hrs.	8 Date of Birth		9 Birthr	lace (State or Foreign
П	Funeral Director			™ M 2□F	66 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) May 9.		Cour	unk
	D		Usual Residence of Decedent					may 9,	1737		
	irylan show	_	10a. State 10b. County		10c. City, Town or I					1	0d. Inside City Limits
	Ba-f s	by Funeral Director	MD		Balt	imore					1√Yes 2□No
	with th	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citize	n of What Cour	ntry?
	s 23	eral	3330 Wilkens Aver	12. Was Decedent	Ever in U.C. 12	212		aif. Van as Na	14	USA Race - Americ	an Indian
40	ther d	-un	11. Marital Status unk 1 □ Never Married 2 □ Married	Armed Forces?		If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	14.	Black, White,	
936	urs at	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Sp	pecify: wh	ite
21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or items 23e or 28e-1 show the Modell Examinational by notified at	Completed	15. Decedent's Ed	fucation	16a. Dec	edent's Usual Occup	pation	unk	16b. Kind	of Business/Inc	dustry unk
21	thin 7	nple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired	during most of worki d)	ng			
	ed wi	Con		nk							
pur	be fill H	Be	17. Father's Name (First, Middle, Last)			unk	18. Mother's Name	(First, Middle, i	<i>Maiden S</i> u	mame)	unk
78	12 should be filed within 7 and Mental Hygiene. T is marked other than "r raumatic event, II:e M. o	T _o		5							
Maryland	ges 1 and 2 should be filed within 72 hours atter death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, Ite Wooted Examinating to collect traumatic event, Ite Wooted Examinating to collect the confilled at	10	19a. Informant's Name/Relationship (and Number or Rura		-		
	1 and Healt em 2		University Specia 20a. Method of Disposition	illy Hosp.	20b. Place of Disp	osition (Name of		-		ID 212	
JO.	Pages nent of int: If it iry or o		1 Burial 2 Cremation 3		,	ematory`or other plac	ce)			,	.,
Baltimore,			'4 □Donation 5 ☒ Other (Specifical Service Licer	In state		22. Name and Addre	ss of Facility				
Ba	permit. Departr Importa		21. Signature of Foneral Service Licer Ronald S	Wade, Dir		tate Anat	omy Board MD 2120		Balt	imore S	treet
	•		2 a. Pa 1. Enter the disease, o com	plications that caused	the death. Do not e				est,		Approximate
	Physician		shoc or heart failure. List only Immediate Cause (Final								Interval Between Onset and Death
	/Medical	21 1	disease or condition resulting in death)	a. Due to (or as	a consequence of):	arrytha	m ca				15 mais
	Examiner		Commented to the same delicate	AH	a consequence of):	reke he	sont al	sease			1045
	n =	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):			-			
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	0.	I be densiter						O
90,	The law requires that the death certiticate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	<u> </u>	resulting in death) cast	Due to (consequence of):						
8760,	physii the t	dlcal		d			· · · · · · · · · · · · · · · · · · ·				
9 X	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy			111	224	Date of delive	
Вох	atten tor u	clan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	1		230	I. Date of delive Month	Day Year
0	that the de ad by the detached	ysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		_ 0 (0,000)/ _					
<u>а</u>	res that igned b		Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did tol	bacco use	contribute to th	e cause of death?
rds	n sign	d be	Respiratory yes	lure, c	eschrims	oular acc	ricen L	1 □ Ye	es 2 🗆 N	lo 3□Prob	ably 4 Dunknown
Records,	aw requir s been si 2 should l	Completed by						24a. Was a	n 2	4b. Were auto	psy findings available inpletion of cause of
R	The it	E					 _	autops perform	ned?	death?	
Vital		a l	25. Was case referred to medical				26. Place of Death				
of V	ding Physiclan: h. After this certifications tuneral director,	To B	examiner? 1 Tes 2 No	Hospital: 1 1 Inpatie	ent 2 ER/Outpatio	ent 3 DOA Oth	er: 4 🗆 Nursing Hor	m <i>e</i> 5 ☐ Reside	ence 6	Other (Specif)	1)
0			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury	of 28c. Injur Wor		28d. Describe ha	ow injury o	ccurred	
sio	death. ctor: A y the tu	catl	2 Accident investigation 3 Suicide 6 Could not b				Yes 2 □ No				
Division	atter d Direct Jin by	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office	4	28f. Location (St City or Town	reet and N n, State)	lumber or Rura	l Route Number,
	pltat vurs a eral C		29a. Certifier 1 Certifying Ph	volcion. To the best	of my kenydadan dan	Alba a a a sure di a A Ab a Ab		and due to the e		d	-1
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely tilled in by the tune	Medical	(Check only 2 Medical Examone)	ysician: To the best niner: On the basis o and manner st	of my knowledge, dea f examination and/or i	nvestigation, in my o	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, d	ause(s) an ate and pla	d manner as st ace, and due to	ated. the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier	\ . /		29c. Licens	e number	2	9d. Date s	igned (Month, i	Day, Year)
	⊢ s ⊢ ŏ		-) ·		D	304014		81	2105	
7			30. Name and address of person who		leath (Item 23a) (Type						
			1		ci suuth		St Ba	1+mare	e mi	0 2123	6
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature						
	Regist	rar	AUG 1 2 200	Media	13 Apa	de					

DHMH 17 Rev 1/2001

George, Donald

Amend item#23a,b,PII.25, perME C846, 8/11/05 TT State of Maryland / Department of Health and Mental Hygiene state of Maryland Department of Health a state of Health a state of Health a state of Health a state of Health a state of Health a state of Health a state of Health a state of Health a state of Health a state of Health a state of Health a sta Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year HENSON EUGENIA JUNE 4:07 P.M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CITY INIVERSITY OF MARYLAND MEDICAL SYSTEM BALTI HORE
If Under 1 Year | If Under 24 Hrs. NIA 8. Date of Birth (Month, Day, Year)
MAY 50, 1957 5. Social Security Number 6/Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 X F 214-72-0968 Yrs Director MARY Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2 No MARYLAND ANNE ARUNDEL Co. 10e. Street and Number Directo GLEN 10f. Zip Code 10g. Citizen of What Country? 5 ROAD Items 23a EV 21060 45A by Funeral 12 Was Decedent Ever in U.S. Armed Forces? 18 Yes, 2 2 8/79 17 Yes, Give Year or Dates: 5/50 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 'natural', Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) i 2 should be filed w. h and Mental Hygien 7 is marked other th 12++GRADE JANITOR HOSPITAL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WILBERT MARSHALL MYRTLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an 7.505 FURNACE BRANCH RD #A GLENBURNIE MD. 21060 Health TERESA JOHNSON (SISTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or o 1 🗷 Burial 2 □ Cremation 3 □ Removal from State ROWNSVILLE CEME 06-30-05 CROWNSVILLE, ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN JR. FUNERAL HOME JOSEPH H. 21. Signature of Funeral Service Licensee FULTON AVE. BALTO, MD. 2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or Superaction of Hemorrhage Examiner Brainstem H Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): P.O. Box 68760, attending physician pe Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 4☐Pregnant at time of death 5 Other (specify) ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Chronic obstructive pulmonary disease; Hypertension 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 25 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this 28a. Date of Injury (Month, Day Year) eral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital overthin 24 hours at 29a. Certifier 🗎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P17749 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARIDI MA alde 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar AUG 1 2. 2005

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July **Physician** 26 Day 2005 6:42 pM Ronald Rexton Hardy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3818 Old Fredrick Rd Baltimore 5. Social Security Number Birthplace (State or Foreign Country)
 NC 7. Age (In yrs. last birthday) **Funeral** 1 ☐**X**M 2 ☐ F Director 213-54-4639 55 Yrs. Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examination must be notified at 1X Yes 2 □ No Be Completed by Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3818 Old Fredrick Rd. 21229 USA Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes Z No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ray Hardy Jr. Arlene White ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and. Department of Health Important: If Item 27 any Injury or other tronce. Sondia Otukoya 2508 Poplar Dr. Balto. Co. 21207 20a. Method of Disposition
14 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Woodlawn Cemetery 8-4-05 Woodlawn, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wesley Chavis Jr. FH 21. Signature of Funer Service Licensee 2007 Eastern Ave. Balto. MD 21231 23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause one Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** no sophary nazal carcinoma years /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (cr as a consequence of). Examine sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): O. Box 68760 inding physician use as the buria To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown bluods 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2♥ No Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 27 Manper of Death 28h Time of 28c. injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D3963 -27-05

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL.

S. Greene St

32_egistrar's Signature

Baltimore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

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AUG 1 2 2005

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ausqust :38 am 2005 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day 9. Birthpla **Funeral** Days Hours 1 ₩ 2 □ F Months Min 213-68-5531 Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No ARUNDEL ANNE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a **)**8 JITEL Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify: Specify: 3 Widowed 4 Divorced "naturai", Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be REID 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is FLETCHER HUTCHINS/BRDTHER 5429 FAURIVER COUMBIA, MD 21044 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 to 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State = ö permit. Page Department of important: If any injury or once. ANATOMY GIFTS REG. ` 4 Bonation 5 ☐ Other (Specify) 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 fe, as a merications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part1. Enter the discuse shock, or heart failure. L Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician adenocascinoma disease or condition resulting in death) O 40055 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a considerance of) the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached o ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Š 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 XNo 1 Yes 2 1 No Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nos Ne 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 1 Natural Injury 5 Pending after death. 1 Tyes 2 No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0051926 eignist 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Gordon 6565 hades Com

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State

Registrar

31. Date filed (Month, Day, Year)

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Physic /Medi		BrENDA	HAM	m		August 5	Day 2005 Year	11:16 A M		
Exami		4a. Fecility Name (If not institution, give s		4b. Ci	y, Town, or Location of Deat	th 4c. County of Death				
		Franklin Square Ho			osedale		BALTIMORE			
Funeral Director		5. Social Security Number 6. Sex 317-74-3438	7. Age (In yrs. I	S Yrs. If Und Month	ler 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day, Ye MAY \$ 1	8. Date of Birth (Month, Day, Year) MAY 9, 1957 9. Birthplace (State or Forei Country) MAY			
yland		10a. State 10b. County		, Town or Location			, ,	10d. Inside City Limits		
death with the Maryland ms 23s or 28s-1 show Inval be notified at	rector	MD N/A)	130	7 LTIMORE	10a	Citizen of What Co	1 Ves 2 No		
s 23s or	Funeral Director	3120 ROSAL			21234		U.S.	9.		
36 s efter	þ	11. Marital Status 1 Never Married 2 Married 2 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:			
215- thin 72 en "nat	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)		life. DO NOT	work done during most of wor use retired)	rking 16t	o. Kind of Business/	Industry		
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S 5 = 5		20a. Method of Disposition → Burial 2 □ Cremation 3 □ R	ellioval itoiti State	lace of Disposition (Nemetery, crematory of	lame of rother place)	Date 200	. Location - City or	Town, State		
Baltimo permit. Page Department of Important: If eny Injury or	1	4 □ Donation 5 □ Other (Specify) 21. 3 nature of Funeral Service License		KLAWN (and Address of Facility	GENTLA EN	SALTO IN	14 A4Th		
Ba perm Depa Impo		Haul M.	Stella	11ART	Tem. and Address of Facility (EU Miller - her Facil	D. BATTO.	NO 203	4		
Priysician /Medical Examiner	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cardiac Arrh Due to (or as a consequence) Due to (or as a consequence)	ythmia uence of):	, , , ,			Approximate Interval Between Onset and Death		
ox 68760, certificate be executed dring physicien and use as the burial-transit	licai	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):	-					
Box 6. death certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	3c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 Ectopic			23d. Date of deli Month	very Day Year		
ords, P.O requires that the een signed by th nould be detache	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the underlying	g cause given in Part I.	23e. Did tobac	-/	the cause of death?		
Sec e taw hes b	Completed					24a. Was an autopsy performed Yes 2	d? death?	topsy findings available completion of cause of		
Vital F sicien: Th certificate rector, pag	BeC	25. Was case referred to medical			26. Place of Dea	ath (Check only one)				
- × · · · · · · · · · · · · · · · · · ·	To E	examiner? 1 2 Yes 2 □ No		ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5□Residenc	e 6 ☐Other (Spec	cify)		
ding h. After		27. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred			
or Atterde Sirecto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, fact	ory, office	28f. Location (Stree City or Town, S	t and Number or Ru state)	ral Route Number,		
Netely filled	edical (29a. Certifier (Check only one) 1 ☐ Certifying Physical Examination	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurr tion and/or investigat	ed at the time, date and place on, in my opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)		
To th within To th compl	Me	29b. Signature and title of certifier	no Chall	aus	O.C.M.E.	Aug	Date signed (Month	05		
		30. Name and address of person who co	mpleted cause of death (Item	123a) (Type, Print) 111 Per	nn Street, Ba	ltimore, M	aryland 2	1201		
St. Regist	ate rar	31. Date filed (Month, Day, Year) AUG 1 2 200	32 Registrar's Signa	f Sparle	,	Asia				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Patricia C. Haas August 705 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Square HUSPI fall Rosedale Baltimore tranklin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 213-30-9526 1 ☐ M 2 🖾 F Yrs Director Oct. 8, 1933 Md. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Md. Baltimore Dundalk 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5 7825 St. Patricia Lane 21222 USA or items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify: Completed by 3 XWidowed 4 ☐ Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other treumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. \$ecretary Financing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H Francis Myers Agnes Myers 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: ff item 27 is rr any injury or other treurr once. Michele Meyer daughter 7825 St. Patricia Lane Dundalk Md. 21222 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Aug. 13te Bayview Crematory or other or other place) Baltimore 4 □ Donation 5 □ Other (Specify) 2005 21 Signature of Fune at Penice Licensee 22. Name and Address of Facility Cornelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 en er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician . Terminal Stage Breast disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner . Metastatic Breast concer to liver and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 2 ☐ No 1 Tes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: dir 1 ☐ Yes 2 No P Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 5 SACagargany RES 000 05 10 30. Name and address of person who completed cause of such (Item 23a) (Type, Print) DR Suganthi Alagarsamy 9000 Franklin Square Drive Baltimore Muryland 31. Date filed (Month, Day, Year) 32. Begistrar's Signature AUG 1 2 2005 Registrar

Registrar

State

31. Date filed (Month, Day, Year) AUG 1

32. gistrar's Signature

111 PENN STREET BALTIMORE, MARYLAND 21201

State of Maryland / Department of Health and Mental Hygien () [] 5 1 - For Stata Registre Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2005 **Physician** AUGUST ARNOLD HEYMAN MARVIN 6:46 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURE CARE CHERRYWOOD REISTERSTOWN BALTIMORE 8. Date of Birth (Month, Day, Year) JULY 20, 1929 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1₩ 2□ F Months Hours 76 MD 214-26-6875 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28e-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23e or 12517 IVY MILL ROAD 21136 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 2 X No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No WHITE Specify: Specify: 3 Widowed 4 Divorced Year or Dates: "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other then "na eny injury or other treumatic avantment." Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN CITY OF BALTIMORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HEYMAN LEVITZ BENJAMIN IRENE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12517 IVY MILL ROAD - REISTERSTOWN, MD 21136 CYNTHIA COHEN / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State BETH TFILOH CEMETERY 08/10/2005 4 □ Donation 5 □ Other (Specify) WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** orra disease or condition resulting in death) /Medical Due to (or as Pulmonary Descripe Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Henknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 **N**o 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this Director: After the 27. Man of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D filled 1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) 1220 Avonue 31. Date filed (Month, Day State AUG 1 Registrar

			1 - For State Registrar	State of Maryland / De	partment of Health and ertificate of Death		ieme 005	26378
			Decedent's Name (First, Middle, Last)			2. Date of Deat	h	3. Time of Death
	Physici /Medio		SISTER JOYCE	HOLDEN, M.H.S.H.		August	9. 2005	2:10A M
	Examir		4a. Facility Name (If not institution, give si		4b. City, Town, or Location of De		4c. County of De	
			THE VILLA		Rodgers Forge		Baltimo	re County
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda M 2♥F 60 Yrs.	y) If Under 1 Year If Under 24 H Months Days Hours M	in. (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
	Director		214-44-4676 Usual Residence of Decedent	60 Yrs.		Mar 8,	1945 M	aryland
	ow at		10a. State 10b. County	10c. City, Town or	Location		*	10d. Inside City Limits
	Mary Ff sh	ţ	Maryland Baltimore	e County T	'owson			1 ☐ Yes 2 🙀 No
	r 28a	Funeral Director	10e. Street and Number		10f. Zip Code	11	0g. Citizen of What (Country?
	th wit	aiD	1001 W. Joppa Road	1	21204		USA	
	ems ems	Iner			 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 	(Specify Yes or No- erto Rican, etc.)	14. Race · An Black, Wh	nerican Indian,
9	or lt	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 💢 No If Yes, Give	1 ☐ Yes 2 X No Specify:		Specify:	White
000	hour tural	d b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	cedent's Usual Occupation		16b. Kind of Busines	
<u>.</u>	in 72	ojet	(Specify only highest grade	completed) (Gi	ve kind of work done during most of v b. DO NOT use retired)	vorking	100. Kild of Busines	Sindustry
7	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Nun		Christian	Ministry
2	be filed within 72 hours after death with the Maryland Ital Hyglene. d other than "natural", or items 23s or 28s-f show event, the Medical Exercitival reast by multipled at	a	17. Father's Name (First, Middle, Last)		18. Mother's N	lame (First, Middle, M	Maiden Sumame)	
<u>a</u>	Alenta Alenta rrked ric ex	To B	Henry R. Holden		Anna	a C. Regan	L	
a S	and N		19a. Informant's Name/Relationship (Typ	e, Print) (P.R.) 19b. Ma	illing Address (Street and Number or	Rural Route Number,	City or Town, State,	, Zip Code)
Σ .`	and and n 27		Sr. Loretta Cornel		01 W. Joppa Road,			
9	of Ho of Hi of Hi or oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Re	camatary c	position (Name of rematory or other place)	Date	20c. Location - City of	or Town, State
	Pag ment lant: jury c		`4 Donation 5 Dother (Specify)	New Cath	nedral Cemetery 8	/12/2005	Baltimore	, Maryland
Daithnor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exacting reast be notified at once.	Total Control	21. Signatural of Funeral Service License		22. Name and Address of Facility Mitchell-Wiedefe	ld Funeral	Home In	
_	70 = 4 0		Martin D. Laws	on	6500 Yerk Read,	Raltimere,	Maryland	21212
			Martin D. T.aws 23a. Pert1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. Do not e e cause on each line.	enter the mode of dying, such as card	iac or respiratory arre	est,	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	multiple in	relona with	matas	taris	17++
	/Medical Examiner		Tosuming in doam,	Due to (or as a consequence of):				
		ii.	Sequentially list conditions, b.	Due to for as a consequence of :				
	uted F Insit	Examiner	cause. Enter Underlying Cause (Disease or injury					
,	execu n and ial-tra	Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
0 / 0 C	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d.					
0	tifical og ph as th	ledi						
Ŏ	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	23b. was decedent pregnant	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 □Ectopic pregnancy		23d. Date of d	
	e dea	sicia	in the past 12 months? 1 Yes 2 No		Other (specify)	·	Month	Day Year
۲.	at the	Phy	9 Unknown			OO+ Bid tob		
ń	res the	by	Part II. Other significant conditions conf	in the transfer for the date of the transfer of the	underlying cause given in Part I.			to the cause of death?
cords,	neen s	Completed					1	TODADIY
ກັ	e 2 s	npi				24a. Was ar autops perform	v prior to	autopsy findings available completion of cause of
	sician: The law requ certificate has been rector, page 2 shoult					1 ☐ Yes 2	2No 1 Ye	s 2⊠No
N I G	sician certif rector	Be	25. Was case referred to medical examiner?	ospital:		eath (Check only one	-/	
5	Phys rthis ral di	T. To	1 ☐ Yes 2 Ø No	28a, Date of Injury 28b, Time	ient 3 DOA 4 Nursing	Home 5 Reside		ecity)
	ding th. Afte fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injur	/ Work? M 1 □ Yes 2 □ No		. ,	
DIVISION	Atten dea octor	ertification:	3 Suicide 6 Could not be	28e. Place of Injury : At home, farm,	street, factory, office		reet and Number or I	Rural Route Number,
5	al or	Sert	4 Homicide	building, etc. (Specify)		City or Town	, State)	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the tuneral director, page	caic	29a. Certifier 12 Certifying Phys	ician: To the best of my knowledge, de	ath occurred at the time, date and pla	ice, and due to the ca	use(s) and manner	as stated.
	he Hi in 24 he Fi	edical	(Check only 2 Medical Exemin	er: On the basis of examination and/or and manner stated.	investigation, in my opinion, death of	curred at the time, da	ate and place, and du	ue to the cause(s)
	With To t	Σ	29b. Signature and title of certifier	K,7000	29c. License number		9d. Date signed (Mor	
			Mian-9	Kish mo	031865		8/11/0	, J
	19		30. Name and address of person who cor		· ·			
				D, 416 E. Joppa Ro		Land 21286)	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 2 2005	32. Registrar's Signature	le			
	3.0.			1-4-1-				

			For State Registrar	State	of Marylan	d / Depa <i>Cer</i>	artment of F	lealth and Death	Mental Hy	giene	005	26379
			1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath		3. Time of Death
	Physicia	_		Lois	F. Howa	ard			Month Augus	Day		7:40 AM M
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	Location of Dea			County of Deat	
			3205 V	Jinnett R	oad		Ch	evy Chas	se		Mont	tgomery
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir	th		hplace (State or Foreign
	Director		214-32-7643	1 □ M 2 🂢 F	70	Yrs.						hington, D. C.
	and W		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	v. Town or Lo	cation		71. 7			10d. Inside City Limits
	faryli sho	ō				,,		-1				1 ☐ Yes 21 No
	28a-	Director	Maryland Mo 10e. Street and Number	ntgomery			10f. Zip Code	hevy Cha	se	10a Citi	zen of What Co	unto/2
	with ta or	<u>=</u>		74	1 1		. u. L.p oodo	20015		rog. om		
	leath	Funeral	11. Marital Status	Vinnett R	cedent Ever in U	.S. 13. V	Vas Decedent of H	20815 ispanic Origin? (\$	Specify Yes or No)- ·	UNITEC 14. Race - Ame	d States
^	fter o	Fun	1 ☐ Never Married 2 ☐ Marri	ed 1 ☐ Yes	orces? 2 🕅 No		Vas Decedent of H f Yes, specify Cuba		rto Rican, etc.)		Black, White	
	urs a	by	3 ☐ Widowed 4 K Divorced	If Yes, G Year or	ive	1	I□Yes 2XINo	Specify:			Specify:	White
2	72 ho	Completed	15. Decedent (Specify only highes		n	16a. Deced	lent's Usual Occup	ation	etrina	16b. Kir	nd of Business/	
<u>''</u>	thin 7	ple	Elementary/Secondary (0-12)		(1-4or 5+)	life. L	kind of work done OO NOT use retired	obling most of we	nking			
V	ed wil	Con		4			Program	Analyst				vernment
200	be file	Be (17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle	, Maiden	Sumame)	
<u>X</u>	Men Men arke	2		Francis H	loward						Mills	
0	2 sh and ts m	a i	19a. Informant's Name/Relations	nip (Type, Print)			g Address (Street					. ,
2 %	and lealth m 27 her ti		Pamela C. Gal	oin/ Daug				Bouleva				ryland 20817
5	ges 1 t of H ff ita or ot		20a. Method of Disposition 1 Durial 2 Cremation	3 ☐Removal from	n State	emetery, cren	sition (Name of natory or other place Nery	(e) A1	Date Igust	20c. Lo	cation - City or	Town, State
	Pag ment tant: jury		`4 □Donation 5 □Other (S)	pecify)	(remato	rium Inc	• 12	. 2005	Ве	thesda,	Maryland
Dallillo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If than 27 is marked othar than "natural; or teams 23a or 28a-f show any injury or other traumatic evant, the Marchal Examinar must be notified at once.		21. Signature of Funeral Service	Licensee	/ / M003	335 Be	Name and Addre thesda-C thesda.	ss of Facility Ro hevy Cha Maryland	bert A. se. Inc. 20814-	Pump 755 3501	hrey Fu 7 Wisco	neral Home/ onsin Avenue
			23a. Part1. Enter the disease, on shock, or heart failure. List	complications that		h. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	nysician ·		Immediate Cause (Final									Onset and Death
	/Medical		disease or condition resulting in death)		astatic (or as a conseq		ıa					6 Months
	Examiner		Conventingly lies annulations	h =====								
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a conseq	uence of):						
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C								
Š	be executed ician and burial-transit	ñ	resulting in death) Last	Due to	o (or as a conseq	uence of):						
0/0	icate be executed physician and s the burial-transit	dlcal		d								
9	entific ding p	d)	IF FEMALE:	220 16 100 0								
200	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	clan/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregna birth 2 - Feta	I death 3	Ectopic pregnancy			2	3d. Date of deli Month	ivery Day Year
j	the s	yslc	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□ Unk	nant at time of d	eath 5	Other (specify)					
Ľ	that the de ned by the a detached t	Physi	Part II. Dther significent condition	ns contributing to	death but not res	ulting in the ur	nderlving cause give	en in Part I.	23e. Did t	obacco u:	se contribute to	the cause of death?
cords,	w requires that been signed b should be deta	d by				•	, , , , , , , , , , , ,					obably 4 Unknown
5	peen peen shoul	ompleted							04-146-		0.45 14/	Anna Badhan mallabla
ั้ม เ	sician: The law certificate has b irector, page 2 s	mpl							24a. Was auto	DSV	prior to death?	topsy findings available completion of cause of
		O								rmed? 2 X No	1 ☐ Yes	2□ No
VII.	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:		55/0	Oth	26	ath (Check only o			
5	> 0 0	-	1 ☐ Yes 2 💢 No 27. Manner of Death	28a. Date		28b. Time of	t 3∐ DOA 28c. Injun	4 🗆 Nursing i	Home 5 K Resi 28d. Describe			cify)
5	ding h. Afte fune	ertification	1X Natural 5 ☐ Pending) (Mo	nth, Day Year)	Injury	Wor	k? Yes 2 □ No			00021100	
VISIOIS	Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could r	ot be 28e. Place	e of Injury - At ho	ome, farm, stre	eet, factory, office		28f. Location (Street and	Number or Ru	ıral Route Number,
	after after Dira	erti	4 Homicide	build	ding, etc. (Specif	y)			City or To	wn, State)		
	spits nours nara / fille	aC	29a. Certifier 1 ☐ Certifyin	g Physician: To th	ne best of my kno	wiedge, death	occurred at the tin	ne, date and place	e, and due to the	cause(s)	and manner as	stated.
	To the Hospital or Attending Phywithin 24 hours after death. To the Funaral Director: After this completely filled in by the funeral.	edical	(Check only 2 Medical I one)	end ma	basis of examina nner stated.	tion and/or inv	estigation, in my o	pinion, death occi	urred at the time,	date and	place, and due	to the cause(s)
	To t To t Com	Σ	29b. Signature and title of certifler	//	#/		29c. License	e number		29d. Date	signed (Month	n, Day, Year)
				Yml	×			00033293		J	August	11, 2005
	in.		30. Name and address of person	who completed cau	use of death (Item	1 23a) (Type, I	Print)					
	12		Frederick P. Sm					e #1300	Chevy Ch	ase,	Maryla	nd 20815
	Sta	-	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ture	1					
	Registr	ar	AUG 1 2 201	33 Jacker	The second							

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			Registrer		Ceni	ricate of L	Jean	2. Date of De	Reg. No.	U5	45380
	Physicia	an	1. Decedent's Name (First, Middle, Last)		1110	050		AU GUST		Year	2.10 P M
	/Medic	al .	DOLORES			BER				2005	Z-10 M
	Examin	er	4a. Facility Name (If not institution, give s		4	4b. City, Town, or			1	nty of Death	1100
			NORTH WEST HOSE 5. Social Security Number 6. Sex		irthda.cl	If Under 1 Year	ACC 5 7				MORE
	Funeral Director			M 2√F 7.5		Months Days	Hours Min	. (Month, Da	iy, _{Year)} 8, 1930) Mary	nce (State or Foreign y)
		-	Usual Residence of Decedent	/ / / /				Juany_r	0, 1930	Taly	Land
	yland		10a. State 10b. County	10c. City, Tov	wn or Loca	tion				10	d. Inside City Limits
	Marfall	ğ	MD Carroll	Finks	sburg						1 ☐ Yes 2. ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Count	ry?
	th will	alD	26 W. Mayer Drive				21048			USA	
	ams er u	ner	11. Marital Status	 Was Decedent Ever in U.S. Armed Forces? 	13. Wa	as Decedent of His es, specify Cubar	spanic Origin? (Specify Yes or No to Rican, etc.))- 14. A	lace - America	
90	or h	J.	1 Never Married 2 Married	1 ∐ Yes 2√∑ No If Yes, Give		Yes 2⊠No	Specify:			cify: whi	
8	be filed within 72 hours after death with the Maryland tal Hygjene. d other than "natural", or Itams 23a or 28a-f ahow evant, Ir.e. Madical Exa citier must be notified at	Completed by Funeral	3X Widowed 4 □ Divorced	Year or Dates:	. Danida	atta Ulawai Oaawa	****				
7	"nat	lete	15. Decedent's Edu (Specify onfy highest grade		(Give kir	nt's Usual Occup <i>a</i> nd of work done d O NOT use retired)	uring most of wo	orking	166. Kind of	Business/Indi	istry
2	withli ene. than	mc	Elementary/Secondary (0-12)	College (1-4or 5+)		operator				a+a11	
0	filed Hygi sthar	ပိ	17. Father's Name (First, Middle, Last)	0	IDA			me (First, Middle		etail ame)	
au	d be ental kad c	To B	John Thomas O'Kee	effe			Ellen	Lenora	Wolff		
Ž	shound M mari	-	19a. Informant's Name/Relationship (Ty	pe, Print) 19	b. Mailing	Address (Street a				vn, State, Zip (Code)
Ž	nd 2 alth a 27 is r trau		Donna L. Carroll/d	aughter	216 G	reenview	Avenue	Reister	stown.	MD 21	136
ē,	s 1 a f Hez itam otha		20a. Method of Disposition	20b. Place	of Disposit	ion (Name of tory or other place		Date		n - City or Tov	
Ë	Page ent o nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ P * 4 ☑ Donation 5 ☐ Other (Specify)	emoval from State	.,,	, ,	1				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Items 23a or 28a-f ahow any injury or othar traumatic evant, If a Mail of Executer must be notified anones.	Ì	21. Signalule of Funeral Service Licens	le de Civantes	22. N	Name and Addres	s of Facility	a 655 W	Rol+i	more Si	reet
m	permi Depar Impo any ir	1. 11	Simul 1	lage (Lector		timore,			Dalli	more 30	reet
-			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death. Do					rrest,		Approximate Interval Between
	Pnysician	5 74	Immediate Cause (Final	CHRONIC OBS	TOUG	TIVE PI	I MONIAG	Y DIS	EARLE		Onset and Death
	/Medical-		disease or condition resulting in death)	Due to (or as a consequence		. 1146 10	C/*(0/0/11	-/ 013	ense		
F	Examiner										
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	e of):						
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S						- 13	
ó	exe ian ar urial-t	EX	resulting in death) Last	Due to (or as a consequence	e of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal		d							
9	artifica ing pl		IF FEMALE:								
Вох	that the death certifi: ed by the attending I detached for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat		ctopic pregnancy				Date of deliver Month	y Day Year
0.	the a	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 🗆 C	Other (specify)					
<u>Ч</u>	d by	Phy	Part II. Other significant conditions con	atributing to death but not reculting	in the und	lorhina equeo ana	n in Part I	23e Did	obacco use co	ontribute to the	cause of death?
ŝ	res than signed to be det	Completed by Physiclan/Me		CT INFECTIO		lerry ing badse give	in in i ait i.		Yes 2□No		/
0	w require been sig should b	etec	O TOTAL TICH		70						
Records,	e law has b ge 2 s	nple						24a. Was		b. Were autop prior to com death?	sy findings available pletion of cause of
		Co						1□ Yes	2 1 No		2□ No
Vital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	/	Othe		eath (Check only			
	Physician: r this certific ral director,	10°	1 Yes 2 No	I I Inpatient 2 LEFENC	Outpatient . Time of	3□ DOA 28c. Injury	4 🗀 Nursing	Home 5 Resi			
Ü.	ding l	ion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work	? ′es 2 □No	20d. Describe	now injury occ	201100	
<u>S</u>	ttenc death stor: / the	ical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home,	farm stree			28f. Location (Street and Nu	mber or Rural	Route Number,
Division of	lor A after Dira	Certification;	4 ☐ Homicide determined	building, etc. (Specify)	iaiti, stroo	n, radiory, omico		City or To	wn, State)		
	To the Hospital or Attending Phys within 24 hours after death. To the Funaral Director: After this completely filled in by the funeral director.		29a. Certifier 1 Certifying Phy	sicien: To the best of my knowledg	ge, death o	occurred at the tim	e, date and place	e, and due to the	cause(s) and	manner as sta	ted.
	e Ho 24 h B Fur	Medical	(Check only 2 Medical Exami	ner: On the basis of examination a	and/or inve	stigation, in my op	inion, death occ	urred at the time,	date and plac	e, and due to	the cause(s)
	ompl	Me	29b. Signature and title of certifier	1//		29c. License	number		29d. Date sig	ned (Month, D	lay, Year)
)	, - p = 0		1	C MI	0	DS	1722		AUGUS	T 8	2005
			30. Name and address of person who co	ompleted cause of death (Item 23a	a) (Type, Pr				7.1.0		
			LEONARD RICHARDSON	N M.D. 5401 OLD	COUR	ET RUAD	RANDAL	LSTOWN	MD 2	1133	
4.	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 0						
	Registi	ar	AUG 1 2 2005	Broken D. A.	poste						

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H			giene Rog. NQ / () [·	20201	
	Physici		Decedent's Name (First, Middle, Last ESTHER)	HART			2. Date of De Month 08	ath Day	Year 2005	3. Time of Death 5:05AM	
	/Medic Examir		4a. Facility Name (If not institution, give MARINER HEALTH O		ILL	4b. City, Town, or FORE	Location of Dec		4c. County			
	Funeral Director		5. Social Security Number 6. Se 215-10-5403 Usual Residence of Decedent	7. Age	(In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min		y, Year)	9. Birthpla Counti	ace (State or Foreign ry) unk	
	Maryland f show	tor	10a. State 10b. County MD Harford	1	10c. City, Town or Lo	st Hill				10	d. Inside City Limits	
	with the	Director	10e. Street and Number 109 Forest Valley	Drivo		10f. Zip Code	21050			10g. Citizen of What Country? USA		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "naturat", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the matited at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	o	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		(Specify Yes or No orto Rican, etc.)	- 14. Rac Blac	e - America ck, White, e	tc.	
21215-0036	d within 72 ho giene. Irre Madical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) unk	e completed) College (1-4or 5+	(Give	dent's Usual Occupi kind of work done o DO NOT use retired SEWIIE	during most of w	orking	own ho		ustry	
Maryland	should be file and Mental Hy, s marked oths umatic evant,	To Be C	17. Father's Name (First, Middle, Last) John W. Mo	rgan			18. Mother's Name (First, Middle, Maiden Sumame) Mary A. Sallman					
	es 1 and 2 sho of Health and f itam 27 is m r othar traum		19a. Informant's Name/Relationship (T) Larry Hartley/sor 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	<u> </u>	522 20b. Place of Dispo	N. Hickor N. Hickor esition (Name of matory or other place	y Avenu			21014		
Baltimore,	permit. Pages Department of Important: If it any injury or o		*4∏Donation 5 □ Other (Specify) 21. Signature → Funeral Service Licens Ronal S	99 1	ton Si	2. Name and Addrestate Anato	omy Boar		Baltim	ore St	reet	
THE PERSON	Physician /Medical Examiner		23a. Part1 Shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	aDue to (or as a	he death. Do not end		g, such as cardi	ac or respiratory a	0	1	Approximate Interval Between Onset and Death	
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	o	consequence of):							
.O. Box 6	law requires that the death certific as been signed by the atlending p 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Da Mo	te of deliver	y Day Year	
Д.	quires that in signed b uld be deta	by	Part II. Dther significant conditions co	ntributing to death but	t not resulting in the u	nderlying cause give	en in Part I.				cause of death?	
al Records,	The ate h page	Completed						24a. Was autop perio 1 □ Yes	rmed2	Were autopoprior to comdeath?	sy findings available pletion of cause of	
ion of Vital	ding Phys n. After this funeral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day	t 2 ER/Outpatier 28b. Time o Year) Injury	f 28c. Injury Work	er: 4 ursing	eath (Check only on the Home 5 Residue) 28d. Describe h				
Division		Certification:	2 Accident 3 Suicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							er or Rural	Route Number,	
	To tha Hospital or within 24 hours after To tha Funaral Dir completely filled in	Medical		sician: To the best of ner: On the basis of a and manner stat	examination and/or in							
	To tha P within 24 To tha F complete	M	29b. Signature and title of certifier	Du		29c. License	3 2 27 ·		29d. Date signed		ay, Year)	
			30. Name and address of person who c DR. DAVID DUNN, 31. Date filed (Month, Day, Year)		PHAIL ROAI	*	R, MD 2	21014				
	Sta Registi		AUG 1 2 2005	A	18 Soul	20						

	1	For State Registrar	State of	f Marylan		artment o		alth and Meath	-	giene	005	26382	
*		Decedent's Name (First, Middle, La	st)	· · · · · · · · · · · · · · · · · · ·					2. Date of De	ath	V	3. Time of Death	_
Physician /Medical			Phy11:	is Diane	e Jon	es			Month AUGUST	Day	2004	111 () 111	
Examiner		la. Facility Name (If not institution, giv		nber)				cation of Death		4c.	County of De	ath	
y aki		SINAT HOSPITA 5. Social Security Number 6.5	ex	BALTIMI 7. Age (In yrs. I			UN M		8. Date of Bir	th	9. B	irthplace (State or Foreign	
Funeral Director		077-50-7258	□M 2 F	47	Yrs.	Months [Days F	lours Min.	(Month, De	y, Year)		Country) A1	
pu .	\vdash	Usual Residence of Decedent 10a. State 10b. County		10c City	r, Town or L	ncation						10d. Inside City Limits	_
th the Marylan or 28a-f ahow		Mđ			ilto	0000000						Yes 2□No	
rect	-	10e. Street and Number		Da	1110	10f. Zip Co	ode			10g. Citi	zen of What C	Country?	
inter death with the Mar utter death with the Mar inter round be indiffed inter round be indiffed Funeral Director		6721 Town Brook 1	Orive			212	207		and the same of th	U	JSA		
er dea		11. Marital Status	Armed Fo	edent Ever in U. rces?	S. 13.	Was Decedent If Yes, specify	t of Hispa Cuban, N	inic Origin? (Spe Mexican, Puerto F	cify Yes or No Rican, etc.))-	14. Race - Am Black, Wh	nencan Indian, lite, etc.	
D36		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Giv Year or D	/ 0		1 □ Yes 20	No S	pecify:			Specify: P	lack	
2 2 2 4 1 -		15. Decedent's E	ducation		16a. Dece	16a. Decedent's Usual Occupation (Give kind of work done during most of working					nd of Busines	s/Industry Unk	-
21215-00 ed within 72 hou ygiene. The than "natural it, the Mcdical it, the Mcdical it.	-	(Specify only highest gra Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use	retired)	ng most or workir	King				
d 212 filed withi Hygiene. other there ent, the M	-	12th grade 17. Father's Name (First, Middle, Last	J	ears		Nurs		. Mother's Name	/Eiret Middle	Maiden	Sumamal		
and bat fad of cever								ary Dunl		, maiden	Jamaine)		
Maryland of 2 should be file tith and Mental Hy 27 is marked other retraumatic event		19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (S		Number or Rura		er, City o	r Town, State,	Zip Code)	
ore, Mass and 2 of Health a litem 27 let cother tra		Brenda D. Jones			55	McKin1	ey A	venue [Jnit D	G-8	White	10606 Plains, N.Y.	
Baltimore, sermit. Pages 1 ar Department of Heal Department of Heal Department if item my injury or other mice.	1	20a. Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐	Removal from	State	emetery, cre	osition (Name matory or othe	r place)	D.	ate	20c. Lo	cation - City o	r Town, State	
Baltimo permit. Pag Department Important: I sny injury o once.		4 □Donation 5 □Other (Special	y)	Ki		norial						own, Md	
Baltimol permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lice	1500	\mathcal{O}	2	 Name and A 430 		Facility Mabash A	March F		West	d 21215	
Ita Water		23a. Part1. Enter the disease, or com	plications that c	aused the death	n. Do not en	ter the mode o					100, 11	Approximate	-
Physician		shock, or heart failure. List only Immediate Cause (Final		ach line. Valvalv	in l	2040	Min	00				Interval Between Onset and Death	
/Medical		disease or condition resulting in death)		(or as a consequ		TO VICE						laay.	_
Examiner		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
Pe sit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consequ	uence of):								
8760, cate be executed physician and the burial-transit dical Examiner		that initiated events resulting in death) Last	c	or as a consequ	uence of):								_
the burial-		(d										
	-	IF FEMALE:											
I Records, P.O. Box 6 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as completed by Physician/Me		23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregna irth 2 Fetal	death 3	□Ectopic preg				2	23d. Date of d	elivery Day Year	
P.O. nat the de d by the a detachad detachad	1												
		Part II. Other significant conditions	contributing to de	eath but not resu	ulting in the u	underlying cau	se given ii	n Part I.	23e. Did 1	tobacco u	se contribute	to the cause of death?	
cords, v requires been sign should be	-								10	Yes 2	□No 3□F	Probably 4. Jonknown	
Vital Records, sician: The law requires to certificate has been signe rector, page 2 should be e.									24a. Was		24b. Were a	autopsy findings available completion of cause of	
									1 Yes	ormed? 2□ No	death? 1 ☐ Ye		
Vital Fician: The certificate rector, page		25. Was case referred to medical examiner?	Hospital:				Other	6. Place of Death					_
on of Vita Jing Physician: After this certific funaral director,		1 ☐ Yes 2 ☑ No 27. Manner of Death		npatient 2 of Injury th, Day Year)	ER/Outpatie 28b. Time o		Injury at Work?	4 Nursing Hon	ne 5 Resi			ecify)	
Division of Ital or Attending Physics after death. Tall Director: After this led in by the funaral did in by the funaral of Certification: To		1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio		th, Day Year)	Injury	м		2 🗆 No					
Divisio or Attendi after death Director: A lin by the fi		3 ☐ Suicide 6 ☐ Could not be determined	280. Place	of Injury - At ho	me, farm, st	reet, factory, o	ffice	2	28f. Location (City or To	Street an	d Number or I	Rural Route Number,	
Division of Vita Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificated filled in by the funeral director.													
		29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example 1	miner: On the b	best of my know asis of examinat ner stated.	wledge, dea tion and/or in	th occurred at nvestigation, in	the time, i my opini	date and place, a on, death occurre	and due to the ed at the time,	cause(s) date and	and manner a place, and di	as stated. ue to the cause(s)	
To the within 2 To the complet		29b. Signature and title of certifier				29c. L	icense nu	ımber		29d. Dat	e signed (Mor	nth, Day, Year)	_
		> kankan	constrain	m		F	CES.	-000		Ale	GUST	9,2005	
10		30. Name and address of person who Ranjami Ramo	completed caus	e of death (Item	23a) (Type	Print)	pila	OC RA					Ī
State		31. Date filed (Month, Day, Year)	A. A	egistrar's Sigga	Ture Ture	M. 2	1.5.50	1 00 170	U I I W				
Registrar													

DHMH 17 Rev 1/2001

Registrar

Kevin Johnson 05-5184 dl

dl			amend item 38 pe	tate of Marylan	d / Depa	JH artment of H	lealth and	d Mental Hy	giene		
		•	1 - State Registrar		Cer	tificate of I	Death		Reg. No. 2	005	26381
P. P.	hyciai	20	Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Year	3. Time of Death
	hysici: /Medic		Kevin E. Johnson					Augus			2:49 P M
E	xamin	er	4a. Facility Name (If not institution, give stree Johns Hopkins Hospi			4b. City, Town, or Baltimo		eath	4c. Coun	ty of Death	
5	neral	3-1 ge			last birthday)	If Under 1 Year	If Under 24 l	Hrs. 8. Date of Bi	th 1963	9. Birthp	lace (State or Foreign
	ector		5. Social Security Number 6. Sex. 1 4 M	2□F	42 Yrs.	Months Days	Hours N	Hrs. 8. Date of 81 (Month, Di 2/20	795	MD	itry)
2	. 12		Usual Residence of Decedent	10.00							
aryla	e hov	ž	10a. State 10b. County		y, Town or Lo					1	0d. Inside City Limits 1 Yes 2 No
the M	280-1	Director	MD 10e. Street and Number	GWY	nn Oa	K 10f. Zip Code			10g. Citizen o	f Mhat Cour	
	i pe	ă	1529 Ingleside Av	70		21207				i wilat Coul	itty r
leeth	TIS 23	Funerai		Was Decedent Ever in U.	S. 13. V		lispanic Origin'	? (Specify Yes or Nuerto Rican, etc.)	USA 0- 14. Ra	ace - Ameno	an Indian,
21215-0036 d within 72 hours after deeth with the Maryland giene.	od other than "natural", or items 23s or 28er show event, the Madical Exprimer must be notified at	by Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cuba I ☐ Yes 2 ☐ No	Specify:	uerto Rican, etc.)		ack, White, ify.Blac	
2 hou	ical E	Completed	15. Decedent's Educati	on	16a. Deced	ient's Usual Occup	ation	wadaa	16b. Kind of	Business/Inc	dustry
21.5 thin 7	Med	pje	(Specify only highest grade co	College (1-4or 5+)	`life. L	DO NOT use retired	auring most of d)	warking			
d 21 filled wi Hygien	= =	ပ္ပ			Labo	rer			Refys		
De its	even even	Be.	17. Father's Name (First, Middle, Last)					Name (First, Middle		ame)	
Maryland od 2 should be filt lith and Mental Hy	Important: If Item 27 Ie marked other than ery injury or other traumatic event, <u>ihe Ma</u> once.	2	Douglass Johnson					e C. Wil		01 . 7	
Man Hand	traun traun		19a. Informant's Name/Relationship (Туре, Pamela Johnson	Print)				r Rural Route Numi			1100
e, No 1 and Health	ther the		20a. Method of Disposition	20b. P		sition (Name of natory or other place		ve. Balt	20c. Location		
no ages	t:		1 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other.(Specify)	Oval Hom State		_	1	0/11/05			
Baltimore,	injur.		21. Signature of Furieral Service Licenses	1	. Car			3/11/05 Wesley C			
Balt permit. Depart	eny ii		1/Onlow /h					Ave. Bal			
	25		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that clused the deatl							Approximate Intervat Between
Phys	ician		Immediate Cause (Final disease or condition	ause on each line.	-	Lougin	-				Onset and Death
	dical		resulting in death)	Due to (or as a consequence	uence of):	17 /11				-	
Exar	niner		Conventingly (internal divine								
T.	=	ner	Sequentially list conditions, if any leading to in reclust cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of						
enne	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1							
30, 8 8 8	cien a		resulting in deathy cast	Due to (or as a consequent	uence of):						
8760,	physicien and the burial-transit	dical	d								
ords, P.O. Box 68760, requires that the death certificate be executed	attending p	/Me	IF FEMALE:	If yes, outcome of pregna	ancy				2011	D-4	
Both e	atten for u	Physician/Me	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	ıl death 3 [Ectopic pregnancy Other (specify)	у			Date of deliv Month	ery Day Year
O 3	E SE	isic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	J_						
D is	signed by d be detac		Part II. Other significant conditions contrib	uting to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use co	ontribute to t	he cause of death?
Records,	n sign	d by			,			1	Yes 2 No	3 🗌 Prol	bably 4 ∐Unknown
O N	s peen s	Completed						24a. Wa	san 24	b. Were auto	opsy findings available
Rec The law	page 2	E O						per	opsy formed?	death?	ompletion of cause of
	certificete rector, pag	0	25. Was case referred to medical				26 Place of	Death Check only	2 □ No	A THIS	2□ No
	w 5	To B	examiner? 1 Yes 2 No	pital: 1 ☐ Inpatient 24☐	ER/Outpatier	nt 3□ DOA Ott		ng Home 5 □ Re		Other (Speci	fy)
of Phy	After th funeral			28a. Date of Injury (Month, Day Year)	28b. Time of		ry at		how injury occ		
Vislon Attending	or: Af	atic		21.11.	Found 13:	. M 1 🗆	Yes 2 No	Subject	+ hard	ed se	4
Division of or Attending	irecte by (Certification:	3 Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	(V)	4 4 . 10		City or T	own, State)		a Route Number,
Urs aft	led in	Se			jai	l Cell		41 East	Madison	St. Ba	Himore, MI)
Division or the Hospitel or Attending F within 24 hours after death.	To the Funeral Director: completely filled in by the	Medicai	29a. Certifier 1 ☐ Cartifying Physici (Check only one) 1 ☐ Madical Examiner	an: To the best of my knoOn the basis of examina and manner stated.	owledge, death ation and/or in	h occurred at the ti vestigation, in my o	me, date and popinion, death	place, and due to th occurred at the time	e cause(s) and e, date and plac	manner as s e, and due t	stated. to the cause(s)
To th withir	To the	M	29b. Signature and title of certifier	4 40		29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)
			Calmiella	h Alla		OCME			August	2. 20	005
			30. Name and address of person who comp	leted cause of death (Iter	m 23a) (Type,		-		riagas c	<u>، ک</u> و <i>ک</i>	
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100	Registi	el.									

Medica kamine		Maurice Edward lac	keon					JULY	$29^{\circ}, 200^{\circ}$	1151 A		
Callline	4	Maurice Edward Jac 4a. Facility Name (If not institution, give street a 2552 MCHENRY STREET					ORE CITY		4c. County of D			
neral ector	- 1	5. Social Security Number 6. Sec. 218-64-2064 1 M 2		(In yrs. last	birthday)	If Under 1 Ye Months Da	ar If Under 24 Hr		(ear) 9. (MI	Birthplace (State or Fore Country)		
fled at	101	Usual Residence of Decedent 10a. State 10b. County MD		10c. City, To	own or Loca					10d. Inside City Lim X☐ Yes 2☐		
to an		10e. Street and Number				10f. Zip Cod		10g	. Citizen of Wha	t Country?		
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i c	e Co	8th 17. Father's Name (First, Middle, Last)			Labor	cer	18. Mother's N	S] ame (First, Middle, Ma	hip Yar aiden Surname)	db		
ic eve	20	Garfield Jackson S	r.					. Chisley	ŕ			
euma		19a. Informant's Name/Relationship (Type, Pri	int)				eet and Number or I	Rural Route Number, (City or Town, 214	00.		
any Injury or other tre		Fanya Taylor 20a. Method of Disposition		20b. Place	of Disposit	Tall tion (Name of atory or other		t. Glen I	Burnie, Oc. Location - City	Md or Town, State		
ury or		1 ⚠ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	al from State		red H	Teart	8-	08-05 Di	ındalk,	MD		
any Inj		21. Signature of Funeral Service Licensee	./ .					esley Cha e. Balto.				
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r, page 2 shou	Completed								ed? dear	e autopsy findings avai to completion of cause fi? Yes 2 No		
al direct	ation: 10 Be	25. Was case referred to medical examiner? 1 \(\tilde{\tilde{X}} \) es 2 \(\tilde{\tilde{N}} \) No 27. Manner of Death 1 \(\tilde{X} \) Natural 5 \(\tilde{\tilde{P}} \) Pending 2 \(\tilde{A} \) Accident investigation	al: 1 Inpatier a. Date of Injury (Month, Day	28	Outpatient b. Time of Injury			eath (Check only one) Home 5 Residen 28d. Describe how	ce 6XOther (Specify) SCENE		
ed in by th	Certification:	a Could not be	e. Place of Inju- building, etc.		, farm, stree	et, factory, of	ice	28f. Location (Stre City or Town,		r Rural Route Number,		
Jetely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: O ar		examination								
comp	Me	29b. Signature and title of certifier	1.00	Mo	9		ense number OCME		Date signed (N	nonth, Day, Year)		

			1 - For State Registrar	State	of Marylan	•	artmen rtificat			nd Me		iene g. No2	005	26386	
	Dhysisi		1. Decedent's Name (First, Middle, I	.ast)						2	2. Date of Deat Month	h Day	Year	3. Time of Death	
	Physici /Medic		Alexande			key					8	6	V _{Aeal}		-
No.	Examin	er	4a. Facility Name (If not institution, g Hospice House	rive street and nu	mber)			Town, or asto:	Location of	Death			4c. County of Death Talbot		
	Function			. Sex	7. Age (In yrs.	last birthday)	If Under		If Under 2		B. Date of Birth			irthplace (State or Foreig	n
	Funeral Director		213-07-1341	¼ □M 2□F	90	Yrs.	Months	Days	Hours	Min.	(Month, Day, NOV. 31			Country)	
	D .		Usual Residence of Decedent 10a. State 10b. County		10° Cit	y, Town or Lo									_
	saryla •hov	Į.		lbot	100. 01	y, rown or Lo	cation	Eas	ston					10d. Inside City Limits 1 ☐ Yes 2X No	
	28a-1	Directo	10e. Street and Number	IDOC			10f. Zip				1	0g. Citiz	en of What (Country?	_
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	death	Funeral	11. Marital Status	12. Was Dec Armed F	edent Ever in U.	.S. 13.	Was Dece	dent of His	spanic Origi	in? (Spec	fy Yes or No- ican, etc.)			nerican Indian,	
စ္တ	or Its	y Fu	1 Never Married 2 Married		2X No	1	1 □ Yes		Specify:	1 4010 11	, dic.,		Specify:		
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2121	e filed within al Hygiene. other than "	luo:	Elementary/Secondary (0-12) 7 Years	College (1-40r 5+)	St	eelwo	rker				S	teel :	Industry	
	be file ital Hyg id othe	Be C	17. Father's Name (First, Middle, La	st)					18. Mother	's Name (First, Middle, M	Maiden S	lumame)		
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Maryland	ages 1 and 2 should b nt of Health and Ment t: If Item 27 is marked / or other treumatice		19a. Informant's Name/Relationship		_						Route Number, Con , Ma:			, <i>Zip Code)</i> 1601	
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Baltimore,	Pages nent of int: if it ury or o		1 ⊠Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	_						Cem.				idge, MD	
=	permit. Page Department of important: fi eny injury or once.		21. Signature Funeral Service Lig		0	22	Name ar	nd Addres	s of Facility	,					
ñ	9 1 2 8		Degan E	Ken							ome of 1 lalk, Ma			21222	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that by one cause on	caused the deat	h. Do not ent	er the mod	de of dying	g, such as c	cardiac or	respiratory arre	est,		Approximate Interval Between	
) 1	Physician		Immediate Cause (Final disease or condition		しいろ		nce							Smonths	
	/Medical Examiner		resulting in death)	Due to	or as a conseq	uence of):		OGO	truct	1112	die.	7/9		10 years	
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3/60,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	icai		d											
ō ×	ertifica Ilng pt	Physician/Med	IF FEMALE:	22. 14								-			
O. Box	leath certific attending p	cian,	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregna birth 2 □ Feta nant at time of d	Ideath 3	Ectopic p					23	3d. Date of d Month	elivery Day Year	
o.	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkr		J. J.		,do::y/							
", J	res that igned b be deta	by PI	Part II. Other significant conditions	contributing to	leath but not res	ulting in the u	nderlying (ause give	n in Part I.		23e. Did tot	oacco us	e contribute	to the cause of death?	
Division of Vital Records,	w require been sig should b	edt									1 □ Ye	es 2□	No 3□1	Probably 4 💆 Unknown	1
ပ္	law re as be	Completed									24a. Was a		prior to	autopsy findings available completion of cause of	8
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Ž	Physician: 1 r this certificat ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Othe	-		Check only on			Assist	:e
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<u>S</u>	r Attendi	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	209. Plac	e of Injury - At he ling, etc. (Specif	ome, farm, str	reet, factor	y, office		28	If. Location (St. City or Town		Number or i	Rural Route Number,	_
5	Itaio Irs aft ral Di led in														
	To the Hospitai or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the aminer: On the I	e best of my kno pasis of examina nner stated.	wiedge, deatl tion and/or in	h occurred vestigation	at the tim , in my op	e, date and inion, death	i place, an h occurred	nd due to the ca d at the time, da	ause(s) a ate and p	and manner place, and di	as stated. ue to the cause(s)	
	o the	Mec	29b. Signature and title of certifier			· · · · · · · · · · · · · · · · · · ·	29	c. License	number		25	9d. Date	signed (Mo	nth, Day, Year)	
	- × + ō) day	a M			- 1							nth, Day, Year)	
6	7		30. Name and address of person wh		se of death (Item	n 23a) (Type,	Print)		5 =	8/10	n MA	1	2/60	, /	
9			Jorge Obre		(91	W999	L OVI	~ C			- / 1/2			,	
2/2	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 2	2005	lances	J. J.	pad	5							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Vea Month 205 AM **Physician** ene lar 2009 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A KESWICK MANOR NURSING HOME BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0C (Month Day), 1917 Birthplace (State or Foreign County) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 👿 F 87 Director 217-09-8540 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 la marked othar than "natural", or Itams 23a or 28a-f shov other traumatic avant, Ita Modical Examinar i ust be notified at 1 ☐ Yes 2 ▼ No Completed by Funeral Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code #605 21208 USA 1 HIGHSTEPPER COURT 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) RETAIL SALES Pages 1 and 2 should be filed nent of Health and Mental Hygisht: If itam 27 la marked othar 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be COHEN LENA KASTEN WOL F 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 HIGHSTEPPER COURT #306, PIKESVILLE, MD 21208 19a. Informant's Name/Relationship (Type, Print) MRS. ELLEN LAFFERMAN / DAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition OHEB SHALOM MEMORIAL AUG.11,2005 REISTERSTOWN, MD 1 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or = 5 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 57 Priysician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day Year Month in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 BNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performe HOSPIC eut 2 🗹 No 1 🗆 Yes Division of Vital To the Hospital or Attanding Physician: funeral director, Be Was case referred to medical examiner? 25 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2@No 1 Inpatient 2 ER/Outpatrent 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 TYes 2 No 2 Accident after death | Director: / d in by the f 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funaral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) Signature and afe of ce 29c. License number 2005

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

death (Item 23a) (Type.

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32. Registrar's Signature

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me and address of per

31. Date filed (Month, Day)

			For State	State of Man		artment of H		lental Hygi	iene					
			Registrar 1. Decedent's Name (First, Middle, Last)			inioate or i	Death	2. Date of Death	2005	23. Time of Death				
	Physici		MARGARET BEATE	RICE KIE	RKBRIDE			AUGUST	Day Year 10, 2005	9:30P M				
	/Medic Examin		4a. Facility Name (If not institution, give s Saint Joseph M	treet and number)	enter	4b. City, Town, or	Location of Death	n	4c. County of Deat	imore				
	Funeral Director		5. Social Security Number 6. Sex 1214-01-2725	M 2XF 7. Age (I	n yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 14	Year) Co	hplace (State or Foreign untry) ryland				
	and w		Usuel Residence of Decedent		Oc. City, Town or L	nantina				10d. Inside City Limits				
	shov	5	Maryland Baltimo		Perry Ha					1 ☐ Yes 2 ☑ No				
	the M	ecto	10e. Street and Number	Le	Terry III	10f. Zip Code		10	og. Citizen of What Co					
	3a or	i D	4100 Chardel Road	Apt. 2-D			21236		U.S.A.	,				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, I're Madical Ext. ill refront the mullified at ance.	Funeral Director		12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐XNo		Was Decedent of H If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White					
920	al', or	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1☐ Yes 2X No	Specify:		Specify: Wh	ite				
21215-0036	n "natur	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work	ting	16b. Kind of Business/	Industry				
212	giene giene er tha	Com	12 years	College (1-401 3+)		Homemakeı	<u> </u>		Own Ho	me				
pu	al Hy d other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam							
yla	ould bent Ment	은		ing	1		Margare		McHugh					
Mar	d 2 sh h and 7 Is π traum		19a. Informant's Name/Relationship (Ty) Donald L. Kirkbri			ng Address (Street) Daniels A			City or Town, State, 2					
e,	1 and Healt Iem 2		20a. Method of Disposition			Datitiets is position (Name of matory or other place			Maryland 2 20c. Location - City or					
Baltimore, Maryland	Pages ment of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ R 1 Other (Specify)	emoval from State	Gardens	of Faith	Cem. 8-1		Baltimore,					
Salt	permit. Departr Importu any inj		21. Signature of Funeral Service License	INI	2 N	2. Name and Addres	ss of Facility Viedefeld	Funeral	Home, Inc	. I Assessed to				
	<u>v</u> ∪ = ≅ ø		John O. Muce	rell		bout tor	k koad R	altimore	, Maryland	21212 Approximate				
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	Physician ' /Medical		Immediate Cause (Final disease or condition resulting in death)	ENCEPHAI						DAYS				
н	Examiner			ACUTE O		IC RENAL	. FAILUR	E		DAYS				
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687	g phys as the	edic												
O. Box	ie death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of 1□Live birth 2 (4□Pregnant at tin 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year				
Δ.	that the de ed by the detached		Part II. Other significant conditions con	tributing to death but i	not resulting in the t	inderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?				
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00	w requir	Completed						24a. Was ar	24b. Were au	itopsy findings available				
Re	The lav	omp						autopsy perform 1 Yes 2		completion of cause of				
ital		BeC	25. Was case referred to medical examiner?				26. Place of Deal	th (Check only onl	A	-70				
of V	is diib	To	1 ☐ Yes 2 No	ospital: 1 Inpatient			4 Industrig Fit		nce 6 Other (Spe	cify)				
ion	ding h. After funes	ertification;	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time (Wor	yat k? Yes 2 □ No	28d. Describe ho	w injury occurred					
Division	- 9	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, si (Specify)	reet, factory, office		281. Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,				
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Diractor: completely filled in by the	edicai (sicien: To the best of rener: On the basis of earth and manner state	camination and/or it									
	To th within To th comp	Me	29b. Signature and title of certifier	222		29c. Licens	e number	29	Od. Date signed (Mont					
	00) (elallos	my		DOOE	25886	(lugust 1	0,2005				
	17		30. Name and address of person who co						· · · · · · · · · · · · · · · · · · ·					
	· CA	ato.	LILIA CEBALLOS 31. Date liled (Month, Day, Year)	M. D. 76 Ø 32. Registrar's		DRIVE T	OWSON.	MARYLAN	ID 21204					
	Sta Regist		AUG 1 2 2005	fee.	H I	. M -								
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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Aug Day Physician 2005 2115 CARL R. KROPLAGE 03 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2 □ F Days Months 434-46-9350 Director July 11, 1934 Usual Residence of Decedent 10c. City, Town or Location 10d. fnside City Limits 10a State 10h County 28a-f show traumatic event, the Medical Examinar must be notified at MD 1 Yes 2 No Howard Sykesville Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö Forsythe Road 238 21784 USA r death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1V_Yes 2 ☐ No It Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) ElectricaliEngineer Engineering 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liury or other traumatic event 2008. Be Armand Kronlage Emily Derouch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Yvonne M, Kronlage (Wife) 14160 Forsythe Road Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2/12/Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 8/19/2005 Sykesville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, P.A. (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCSIZ LUNG **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine Attending Physician: The law requires that the death certificate be executed in death. that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical *IF FEMALE* 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the gause of death? Completed by CORONARY ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTSNSION. 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2F No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Au6 09,2005 1)18457 MB laward 4.-PATUXENT PKWY 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) / 1 055 L/TTLS SCHAEFER MD EDWARD w. COLUMBIA. MD 32. Pagistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) AUG 1 2 2005

			State Amend Item 1&	State of Ma Unpend Ite	aryland/ em 23a&	Dера 27 - Р	rtment	of H	ealth a	and M 6-05	ental Hy tas	giene		20200
	Physici	an	1. Decedent's Name (First, Middle, Las Shellia Ma	t)							2. Date of De. Month AUGUST	ath	2005°	3. Time of Death 1:54P. M
	/Medic Examin		4a. Facility Name (If not institution, give 6 STABLE RUN COUR'	street and number)			4b. City,		Location o	of Death	1100001	4c. Cou	nty of Death	h
	Funeral Director	8	Social Security Number		9 (In yrs. last	birthday) Yrs.	If Under Months		If Under :	24 Hrs. Min.	8. Date of Bird (Month, Da Jan 18	h	9 Rint	nplace (State or Foreign unity) Virginia
	ryland thow	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	cation							10d. Inside City Limits
	the Ma	ecto	Maryland Baltin	nore		Randa	11sto					10g. Citizen	of What Co	1 ☐ Yes 2X No
	th with	al Di	6 Stable Run Cour	t				211.	33			•	USA	,
036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examinal must be notified at	by Funeral Director	11. Marital Status X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Amed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Vas Deced Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	1	lack, White	rican Indian, e, etc. iite
Maryland 21215-0036	I within 72 ho iene. r than "natur the Wedical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5			ent's Usua kind of wor OO NOT us Ver Wo	k done d e retired)	luring most)	t of workii	ng	16b. Kind of	Business/I	industry
yland	should be filed and Mental Hygid s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Ma										,	
Mar	s 1 and 2 should if Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (7) Linda Greig, Sibl	•			-				Route Numbe Ve Taur			ip Code) nd 20707
	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □	O	20b. Place ceme	of Dispos tery, crem	sition (Nam latory or of	ne of ther place	9)	D	ate	20c. Locatio	n - City or	Town, State
altimore,	orte		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Line)		Metro									Maryland
ä	Ped die		Thomas Gregor	7									nc. laryla	and 21228
養	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each ling. Seizure a.	10.		er the mode	e of dying	, such as	cardiac o	r respiratory a	rest,	The state of the s	Approximate Interval Between Onset and Death
	/Medical Examiner	_		Due to (or as	a consequenc	ce of):								
W. A.	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as						<u>.</u>				
	# × 9	Ical	Tosulang in Godin) East	Due to (or as	a consequenc	:e oi): 								
O. Box 68	the death certifical y the attending phy iched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pro						Date of deli	very Day Year
rds, P	w requires that the de been signed by the a should be detached f	by	Part II. Dther significant conditions or	ontributing to death b	ut not resulting	g in the un	derlying ca	ause give	en in Part I.		23e. Did to	-		the cause of death?
al Records,	Physician: The law requires that the this certificete has been signed by the rail director, page 2 should be detached.	Completed									24a. Was autor perfo	rmed?	b. Were au prior to death?	topsy findings available completion of cause of
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Division of Vital	ding h. After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da)		o. Time of Injury		8c. Injury Work		2	28d. Describe I			"" SCENE
DIVI	al or Attency s efter death al Director: ad in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, c. <i>(Specify)</i>	farm, stre	et, factory	, office		2	28f. Location (3 City or Tov		mber or Ru	ral Route Number.
	Fo the Hospital or Attenty within 24 hours efter deal To the Funeral Director:	edical (29a. Certifier (Check only one)	ysicien: To the best liner: On the basis of and manner sta	examination	dge, death and/or inv	occurred estigation,	at the tim in my op	e, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
	within 2 To the	Me	29b. Signature and title of certifler	AN	11/	\		. License				29d. Date sig		
\cap	8 Bur		30. Name and address of person who	completed cause of d	eath (Item 23		Print)	O.C.1	-			UGUST		
0	Sta		31. Date filed (Month, Day, Year) AUG 1 2 2	32. Pegistra	ar's Signature				STRE	ET, B	ALTIMOR	E MARY	LAND	21201
13	Registr	ar	HOR IS Z	UU3 COM	er Signature	Ap	sel.							

		•	For State Registrar	State of N	/larylar	•	artment o				-	005	26391
	Physici	an	1. Decedent's Name (First, Middle, L	ast)						2. Date of Deat Month	h Day	Year	3. Time of Death
,	/Media			Glor		Jean	,	ird	15	August		2005	11:05 A ^M
).	Examir	er	4a. Facility Name (If not institution, g		r)			m, or Location of 1timore		7.7	4c. Col	unty of Death	/A
	Funoval		310 South Macor 5. Social Security Number 6.		Age (In yrs.	last birthday)	If Under 1 Ye	ear If Under	24 Hrs.	8. Date of Birth			
	Funeral Director		219-40-1387	1 □ M 212 F	63	Yrs.	Months Da	ays Hours	Min.	(Month, Day, Sept. 2.	^{Year)} 3 , 194	1 Mar	place (State or Foreign htry) yland
	DC *		Usual Residence of Decedent 10a, State 10b. County		10c Ci	ty, Town or Lo	eation					1	0d. Inside City Limits
	Aaryla Fed et	5			100.01	ty, rount of Lo		1+:	· 0:+			'	1 ∑ Yes 2 □ No
	28a-	Director	Maryland N/I 10e. Street and Number	A.			10f. Zip Coo	ltimore	CIC		0g. Citizen	of What Cour	ntry?
	3a or	<u></u>	310 South Mad	con Street				21224			Unit	ed Stat	tes
	deatl	ner	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U	l.S. 13.	Was Decedent	of Hispanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
36	or It	교	1 Never Married 2 Married	1 ⊟ Yes 23€ If Yes, Give	Mo		1 ☐ Yes 2 🛣					ecify: Whi	
Ö	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ehow he Medical Exeminar must be notified at	Completed by Funeral	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's	Year or Dates	I.	16a Dece	dent's Usual Oc	cupation		1		WN1	
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21215-0036	d with	E	Elementary/Secondary (0-12) 12 Years	College (1-4o	r 3+)	H	omemake	r			Ow	n Home	
2	al Hy d oth	Be	17. Father's Name (First, Middle, Las	st)				18. Mothe	er's Name	(First, Middle, M		name)	
yla	Ment Marke	၉	Joseph Laird							Ellie :			
Maryland	d 2 sh th and 7 le m traum	i I	19a. Informant's Name/Relationship Anthony Laird	(Type, Print) (Son)						d Route Number Balti			and 21224
<u>ق</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show appropriately from the traumatic event, the Medical Examinational be notified at ances.	1	20a. Method of Disposition	ilea	20b. F	Place of Dispo	sition (Name o	f	C	ate	20c. Locati	on - City or To	own, State
9	Pages ent of nt: If I		1 ☐ Burial 25 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		e 1		natory or other Servic		. 8/	8/2005	Tow	son, Ma	aryland
Baltimore,	Dermit. Departm Importal any Inju	1	21. Sign we of Funeral Service Lie			6	2. Name and Ad	dress of Facili	y _{al H}	lome of	Dunda	lk, In	C.
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	Physician /Medical Examiner		Part1. Enter the disea e, or co shock, or heart failine. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a Due to (or a	as a consec	ASC (uence of):	-VD	00 - 1i	518	2			Approximate Interval Between Onset and Death
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Division of Vital Records,	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2	ıtlon: To	1 Yes 2 No 27. Manner of leath 1 Natural 5 Pending 2 Accident investigat		Other: 4 Nu Injury at Work? 1 Yes 2		me 5 Reside 28d. Déscribe ho		Other (Specificurred	y)			
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	Tot Tot Tot	Σ	29b. Signature and title of certifier	all	iche	ていり	29c. Lic	ense number	03	2:	9d. Date si	gned (Month,	Day, Year)
	7		30. Name and address of person wh	o pleted cause of	f death (Iter	n 23a) (Type,	Print)	2	20	PAE	95	evn	Ave
	Sta	10	31. Date filed (Month, Day, Year)	32. Reads	- L-I	ature	red ()	- 16	b=1	100	MD	-31	2-4
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Amend item#4a-b, perMD, G846, 8/12/05 TI
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20 **Physician** PM WETH 2005 /Medical 4b. City, Town, or Location (City, Town, or Location (City) Hill 4a. Facility Na Ro (Let in Stitution give sven and sumber) 4c. County of Death Examiner -ARFORD If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 098.32.083 12 M 2 F Yrs GERMANY Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County other treumetic event, the Medical Examinar must be notified at 1 Yes 2 No Director HARFORD FOREST 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö J5A or Items 23e Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify WHITE by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene." 7 Is marked other then "na Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LIVETH OHFER FRIEDRICH SERTURI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or other treum onco. ELEN WETH, WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HILL * 4 ☐ Donation 5 ☐ Other (Specify) TUNERAL POREST 22. Name and Address of Facility EVAN'S FUNERAL CHAPEL - TEL ALL 21. Signature of Funeral Service Licensee FOREST HILL, MO 21050 MOIZZO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HyperKalemia Physician disease or condition resulting in death) /Medical Due to (o Examiner Rena ailure Sequentially list conditions, Due to for as a conseque Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabete Due to (or as a consequence of) the attending physician 68760 Physiclan/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, by Peripheral vascular disease, 3 Probably Depression 1 ☐ Yes 2 ☐ No 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No obstructive 24a. Was an autopsy hyperlipidemia uropathy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) ASSISTED 1 Yes 2 10 2 LIVING 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division e Hospitel or Attending 24 hours after death. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) peake 520 312 hesa er 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2. 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month AUGUST **Physician** 9, 2005 Walter Stinson Manning 6:40p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV 14, 1942 Funeral Birthplace (State or Foreign Country) 1**√** M 2□ F Months Days Hours Min 579-56-0436 62 Yrs. Director Ohio Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10a State 10d. Inside City Limits or 28a-f show traumatic avant, the Medical Exeminar must be notified at 1 ☐ Yes 2X No Director Maryland Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a USA 6655 Sykesville Road 21784 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2★ No If Yes, Give³
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced 1 and 2 should be filed within 72 hours Health and Mental Hygiene. 9m 27 is marked other than "naturat", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuat Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John George Manning Marjorie Caroline Ebert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 Is any injury or other traun Katharine Manning/sister 5501 Yorktown Blvd. Arlington, VA 22207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 TCremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/10/05 Baltimore 21. Signature of Funeral Service Licensee ²² Name and Address of Facility
Cremation Society of Maryland, Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final HEART FAILURE **Physician** ONGESTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): Tary, Isaong to in modic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ signed to d be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 2[] No 1 🗌 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Ptace of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attanding Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Coutd not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours af To the Funaral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8/10/05

State Registrar 1ARIG

31. Date filed Morth Day, Year) AUG 1 2 2005

Aparte

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHMOOD M.D.

Ray, Year, One P. Registrar's Signature

Dulaney Valley Rd.

Timonium, HD 21093

			1 - For State Registrar		aryland / De		f Health a	and Mental Hy	giene)5 26394						
	Ц.,		1. Decedent's Name (First, Middle, La	st)				2. Date of De		3. Time of Death D						
	Physici: /Medic		Frances L. Mix					Honth	10 3	1005 7:50 M						
4	Examin	er	4a. Facility Name (If not institution, give				n, or Location o		4c. County							
			ST Aques 5. Social Security Number 6.5	blospi Gex - 7.4	ge (In yrs. last birtho		ar If Under	24 Hrs 9 Date of Bir	th	N/A 9. Birthplace (State or Foreign						
	Funeral Director			1 M 2 F	77 Yrs	Months Da		Min. (Month, Da Nov. 6	1927	Country) Maryland						
	ס		Usual Residence of Decedent													
	anylar show	_	10a. State 10b. County Balti	more	10c. City, Town o		timore			10d. Inside City Limits 1 ☐ Yes 2 ☐ No						
	Ba-f	ecto							100 00000000000000000000000000000000000							
	a or 2	Θ	10e. Street and Number 920 Courtney Roa	a		10f. Zip Cod	21227		10g. Citizen of V							
	ns 23	Funeral Director	11. Marital Status	12. Was Deceder	t Ever in U.S.			gin? (Specify Yes or No i, Puerto Rican, etc.)		ted States e - American Indian,						
Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artificial of Health and Mental Hyglene. Ortent: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show injury or other traumatic evant, Ita Medical Exaction must be notified at injury or other traumatic evant, Ita Medical Exaction must be notified at 8.	b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates	ŽNo	If Yes, specify 0		, Puerto Rican, etc.)	Specify	ck, White, etc. White						
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2	filed with Hygiene. Ither than		17. Father's Name (First, Middle, Last	·)			18. Mothe	er's Name (First, Middle								
an	d be ental ked o c eva	To Be	Charles Durham	,				lla Durham	0.00	,						
ary	2 should be and Mental is marked c	-	19a. Informant's Name/Relationship	Туре, Print)	19b. M	ailing Address (Str		er or Rural Route Numb	er, City or Town,	State, Zip Code)						
	1 and 2 Health a lam 27 is		William H. Mix I	II Son	130	6 Delphi	Road,	Bel Air, MI	21014							
Baltimore,	of He of He fitam		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Stat		sposition (Name or crematory or other	f place)	Date	20c. Location -	City or Town, State						
Ĕ	permit. Pages Department of bearing in its its any injury or of once.	1	`4 □ Donation 5 □ Other (Speci	(y) \(\int \(\)	Loudon P	ark Ceme		8-15-2005		more, MD						
3all	permit. Pag Department Importent: any injury o	(21. Sign dura of Funeral Service Lice	eezn	Dely			y Ambrose Fu								
	40280		23a Part 1 Enter the disease or con	unlications that caus	ed the death. Do not											
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deat													
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Fix www.h.t. Due to (or as a consequence of):													
Н	Examiner		Due to (or as a consequence of):													
	D #	ner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a consequence of):											
X	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		RUDIUM is a consequence of):	DIFFI	CILLE	COLITIS		2 WEEKS						
120,	tte be executed tysician and ne burial-transit	cal E	100011119 111 000111) 2200	4.4	A TA		enl.			2 yerms						
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P.O. Box	The law requires that the death certificate tate has been signed by the attending physicage? should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death at time of death	3 □Ectopic pregna 5 □ Other (specify			23d. Dat Mor	e of delivery nth Day Year						
	that the		Part II. Other significant conditions	_	_	, ,	given in Part I.	23e. Did t	obacco use conti	ribute to the cause of death?						
Records,	w requires that been signed b should be deta	Completed by	CANDIDA	ES	DPHAC	20Th		1 🗆	Yes 2□No	3 ☐ Probably 4 ☐ Unknown						
00	aw re	plet	ANASI	HR CSA				24a. Was	an 24b. V	Vere autopsy findings available prior to completion of cause of						
	The law cate has page 2:	Com						perfo	ormed?	leath?						
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of \	Phyalo this or al dire	မ	1 ☐ Yes 2 ☐ No		tient 2 ER/Outpa	tient 3 DOA	Other: 4 🗆 Nu	rsing Home 5 Resi								
OU C	ding Ph h. After th tuneral	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Ir (Month, L	ijury 28b. Tim Day Year) Inju		njury at Work? 1 □ Yes 2 □ I		how injury occurr	ea						
Division	I or Attendiater death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not to	28e. Place of I	njury - At home, farm			28f. Location (er or Rural Route Number,						
Div	al or / after 1 Dire d in b	Serti	4 Homicide	building,	etc. (Specify)	•		City or To	wn, State)							
	To the Hospital or Attending Phyalcian: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the bes miner: On the basis and manner	of examination and/o	eath occurred at the r investigation, in n	e time, date an ny opinion, dea	d place, and due to the th occurred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)						
	To the within To the comp	M	29b. Signature and title of certifier	Ho	WE		ense number			(Month, Day, Year)						
•) Journey	-is p	HYSIUM.	2	572	16	AUG	10, 2005						
	di		30. Name and address of person who	completed cause of	death (Item 23a) (Ty	no Drint)		0								
	1			Tko, m.		CATUN	HVE	, JSAL TIN	hort,	mp 2/229						
	Sta Registr		31. Date filed (Month, Day, Year)		strar's Signature	1.1.										
DH	MH 17 Rev 1/2		AUG 1 2	UUD J	He Di	COSNEL										
					ORIGI	NAL										

State of Maryland / Department of Health and Mental Hygien 0 0 5 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death AMBUST ^DI'0, 2005 **Physician** MIASEK 6:35P /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 M 227 217-24-0902 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner material in the material and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMONE MD by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CLEARVIEW U.S.A 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No II Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2☑No Specify: 3 Widowed 4 □ Divorced WhiTe 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1275 ACCOUNTANT TexTILE CORP. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Richard PARSONS KING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 183 SON DELRAN N.J. 08075 William WRSTOVER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/12/05 BAYVIEW CremaTory Balto. Ms * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility - STELLA FUNERAL HOME CITID. laul. M Balto. 7527 hai FURD RO. /23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RUPTURED ABDOMINAL AORTIC ANEURYSM Proysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the leading to the leadin Due to (or as a consequence of): Examiner The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2/2/00 1 Yes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Dopatient 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28d. Describe how injury occurred 1 🗷 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medicai and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 2 2005 Registrar

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>		of Health a		tal Hygie	2000	263	0.6
			Decedent's Name (First, Middle, Last)					2. [Date of Death		3. Time o	of Death
	Physici		Robert Earl McLe	ndon Jr				1 10	Month OGUA	Day Yes	ar 17	OSP M
46.0	/Medic Examin		4a. Fecility Name (If not institution, give si	treet and number)		4b. City, To	wn, or Location		Just	4c. County of D		
			Union Memorial			Balt:	imore					
	Funeral		Social Security Number 6. Sex	7. Age	(In yrs. last birthda)) If Under 1 Y	ear If Under		Date of Birth	9. l	Birthplace (State	or Foreign
	Director		243-22-3901	M 2UF	77 Yrs.			1	Month, 8ay, 26	8, No	Country)	
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation					10d. Inside C	City Limits
	Aaryli sho	5	MD		Baltimo							s 2 No
	28a-	Director	10e, Street and Number		Darcino	10f. Zip Co	nde		100	Citizen of What	Country?	
	with Sa or	<u>ā</u>	3601 Greenmount	λτο		212				SA		
	Jeath Tre 23	Funeral		2. Was Decedent E	ver in U.S. 13		t of Hispanic Ori Cuban, Mexicar	igin? (Specify			merican Indian,	
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ğ	ref, c	3	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes ŽE	No Specify:			Specify: B	lack	
2-0	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "naturel", or lleme 23e or 28e-f show event, the Mudical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dec	edent's Usual C	occupation	t of working	16	o. Kind of Busine	ss/Industry	
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2	e filed within al Hygiene. other then ' vent, the Mu		8th		Мест	nanic	10 14-15	-d- M (Fi			5	
and	be fi	Be	17. Father's Name (First, Middle, Last)	J C					st, Middle, Mai			
ž	2 should be and Mental is marked o	၉	Robert E. McLend 19a. Informant's Name/Relationship (Typ		19h Mai	line Address (S			1. McL	ity or Town, State	o Zin Code)	
Maryland 21215-0036	permit. Pages 1 and 2 should by Department of Health and Menia Importent: If item 27 Is marked any injury or other treumatic events.		Gloria Burrell	e, rini						D 2121		
رة م	1 an Heal Iem 2		20a. Method of Disposition		20b. Place of Disa	osition (Name	of .	Date		Location - City		
Baltimore,	ages int of t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Bayvie	ematory`or othe		8_08_0	15 Du	ndalk,	MD	
₽	artme orten injur		21. Signature of Funeral Service License	· 11//						vis Jr		
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	On states		Immediate Cause (Final	e cause on each en		1111					Interval Be Onset and	Death
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oʻ	e exe ian ar irial-t	EX	resulting in death) Last	Due to (or as a	a consequence of):							
8760,	cate be executed physician and the burial-transil	dical	d.									
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Вох	eath certifi attending for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome of 1□Live birth	2 Fetel death 3	□Ectopic pregr				23d. Date of Month		Year
0	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t 9☐ Unknown	time of death 5	☐ Other (s <i>pecit</i>	у)					
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ĕ	a 25 CA	Completed							24a. Was an autopsy performed	prior	autopsy findings to completion of o	cause of
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Division of Vital Records,	Hospitel or Attending Phyelcian: 44 hours after death. Funeral Director: After this certition tely filled in by the funeral director,	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	nt 2 ER/Outpatio	2000	Othor	of Death (Ch		- 0 TO: /0	1 4 1	
οţ	Phy r this sral d	. To	27. Menner of Death	28a. Date of Injury	y 28b. Time		Injury at		Describe how i	e 6 □Other (S injury occurred	pecity)	
9	th. : Afte	it o	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year) Injury	м	Work? 1 ☐ Yes 2 ☐	No				
<u>Visi</u>	Attend r death ector: / by the f	III C	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ry - At home, farm, s	treet, factory, of	fice	28f. L	ocation (Stree	t and Number or	Rural Route Nur	nber,
ā	el or A s after Il Direct	Certification:	4 D Hornicide	building, etc	. (Specily)			,	City or Town, S	(419)		
	ospit hour uners ty fille		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin									- \
	To the Hospitel or Attending Phyelcian: The within 24 hours after death. To the Funeral Director: After this certiticate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examination one)	and manner state	ted.	nvestigation, in	my opinion, dea	in occurred at	the time, date	and place, and c	ue to the cause(5)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1/11	1	29c. Li	cense number	4 +	29d.	Date signed (Mo	onth, Day, Year)	
			· Muchael	Mes	Don, mo	D	00 54	1787	A	ugust	4,20	05
			30. Name and address of person who con	M	eath (Item 23a) (Type	00	6-1	11-00	1 1	8		M
			31. Date filed (Month, Day, Year)	1 1	r's Signature	Mena	rial	LOSKI	101	DOITIN	iore,	עויו
	Sta Registr		AUG 1 2 2005	Mary .	13 Apres	20		,				

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			Registrar 1. Decedent's Name (First, Middle, Last)			tinoate of L	Joan	2. Date of Dea		* 1,3	3. Time of Death
	Physicia		Jose	Monleon				AUGUST		Year	05:12 A
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deat		4c. County of		03.12.
	Lxamiii	C.	Union Memorial Ho	nspital		Balt	imore		N/A		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.				lace (State or Foreign
	Director		138-48-0087	(M 2□F 5!	Yrs.	Mortins Days	Hours Will.	May 14.	, 1950		occo
	pu *		Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Lo	cation				1	0d. Inside City Limits
	sho	ō		1.00.						,	1 □XYes 2 □ No
	the N	Director	Maryland N/A 10e. Street and Number		Baltimo	10f. Zip Code			I0g. Citizen of W	hat Cour	itn/2
	with a or			· · · +		21211			U.S.		wy:
	leath	Funerai	601 W. 40th Stre	12. Was Decedent Ever in	U.S. 13.		spanic Origin? (S	Specify Yes or No-			an Indian,
	r Iter	표	1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ☐ No		Was Decedent of Hi f Yes, specify Cuba			Black	, White,	etc.
93	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1XXYes 2□No	Specify: Sp	anısh	Specify:	Whi	te
2	filed within 72 hours after death with the Maryland Hygiene. Hygiene then "natural", or Items 23a or 28a-f show ther than "natural", or Items 23a or 28a-f show ant. It is Madical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wo	rkina	16b. Kind of Bus	siness/Ind	dustry
2	ithin nan *	npie	Elementary/Secondary (0-12)	College (1-4or 5+))				
2	led w lygier her th		47 February News (Constitution Local)	5+	Pi	rofessor	40 Markada Na	me (First, Middle, i	Univers		
ano	be de la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last)							9)	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Manhal hygiene. If Health and Manhal hygiene I hygiene 1 terms 23a or 28a-1 show item 27 is marked other than "natural, or liems 23a or 28a-1 show other traumatic evant. It s Manical Examinar must be notified at	^L	Antonio Moni		10h Mailir	ng Address (Street a	Julia		ncha r. City or Town	Stata Zin	Codol
<u>a</u>	d 2 sho th and 7 is m traum	ř i				W. 40th S					
	s 1 and 3 f Health item 27 other tr		Barbara Zecch		Place of Dispo	sition (Name of		Baltimore Date	20c. Location - (
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altimore,	E 60 3	ı	21. Sinte ure of Riveral Service License			2. Name and Addres					
Ba	permit. Departi Import any inj		* fail without			1050 York		Towson.	son Fune Marylan	rai d 2	Home, Inc. 1204
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	V	ath. Do not ent						Approximate
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	/Medical		disease or condition resulting in death)	Due to (or as a cons						-	manths
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	₽ =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):						
19	ecutè ind trans	Examin	that initiated events cresulting in death) Last								
8760,	be executed sician and burial-transit	Ë	resulting in death) cast	Due to (or as a cons	equence of):						
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×	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	(a)	IF FEMALE: 2	3c. If yes, outcome of preg	inancy				23d. Date	of dolive	ND/
Вох	atten for u	Physician/M	in the past 12 months?	1 Live birth 2 Fe 4 Pregnant at time o	etal death 3	Ectopic pregnancy Other (specify)			Mon		Day Year
o	that the de led by the a detached	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	00	3 Gallet (b) Goolly)					
<u> </u>	es that igned b be deta	by Pł	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	23e. Did tol	bacco use contri	bute to th	ne cause of death?
Records,	n sign							1 🗆 Y	es 2 🗆 No	3 🗌 Prob	ably 4 Unknown
Ö	tw require s been si should I	jete						24a. Was a	ın 24b. W	ere auto	psy findings available
Re	The lavate has page 2	Completed						autops perfori	med? de	eath?	npletion of cause of 2 No
Vital		BeC	25. Was case referred to medical				26. Place of De	ath (Check only on			28110
	S .S .D	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 npatient 2	ER/Outpatier	it 3□ DOA Othe	er: 4 🗆 Nursing l	Home 5 Reside	ence 6 □Othe	r (Specify	1)
0	ding Ph .r After th funeral		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	28c. Injury Work	at c?	28d. Describe ho	ow injury occurre	d	
Division of	tendir feath. tor: Af the fu	atic	2 Accident investigation				Yes 2□No				
Ž		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, office		28f. Location (St City or Town	treet and Numbe n, State)	r or Rura	I Route Number,
۵	ital curs af	Ce	——————————————————————————————————————					ki.			
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	29a. Certifier (Check only one) 1 Certifying Physical Exemination (Check only one)	sicien: To the best of my k	nowledge, deatl nation and/or in	n occurred at the tim vestigation, in my op	ie, date and placi pinion, death occi	e, and due to the caurred at the time, d	ause(s) and mar late and place, a	nner as st nd due to	ated. the cause(s)
	thin 2 the the	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	2	29d. Date signed	(Month,	Day, Year)
	F ₹ F 8		. / .	leman, M.I	\		43892		August	11	2005
•	gel.		30. Name and address of person who co	moleted cause of death (It	om 23a) /Type	Print\			109051	11/	2003
	()		Lattina Lemon,	M.D. (II	NION A	MEMORIA	L HOSP	ITAL.	Baltim	oce.	DM
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	· · · · · · · · · · · · · · · · · · ·	1.001	- 1/10	11· 1		-
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			State of Maryland		icate of			Reg. No.2 () () 5	26398
T	Physicia	an	1. Decedent's Name (First, Middle, Last)		+-1		2. Date of De Month	Day Year	3. Time of Death
	/Medic	al	4a Facility Name (If not institution, give street and number)	Me	mit	4b. City, Town, or	Location of Dat		
1	Examin	er	7710 TRAPPE RO	GA		Batti	more		more Co.
	Funeral Director		5. Social Security Number 219-10-2166		Under 1 Year onths Days	If Under 24 Hrs Hours Min.	(Month, Da		thplace (State or Foreign ountry) aryland
	ryland show			Town or Location	on	•			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the Ma 28a-f	Director	Maryland Baltimore 10e. Street and Number	1	Of. Zip Code	Dunda1	ζ	10g. Citizen of What C	
	3a or		7710 Trappe Road	,	oi. Zip oodo	21222			ed States
	r deat	Funerai	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	13. Was	Decedent of H s, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - Am Black, Whi	
020	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or Items 23a or 28e-f show event, the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ No WWI	I 6 1□	Yes 2XXXNo	Specify:		Specify:	White
Maryland 21215-0020	"natur	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent'	s Usual Occup	ation during most of wo	rking	16b. Kind of Business	/Industry
212	iene. than the Ma	ошо	Elementary/Secondary (0-12) College (1-4or 5+) 7 Years		worker	<i>'</i>)		Steel In	ndustry
nd	m = 0 5	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle	, Maiden Surname)	
ryla	Mer Mer arke	ို	Russell C. Merritt, Sr.	10b Mailing A	ddross (Strost		nna M. F	eister er, City or Town, State,	Zin Code)
	d 2 s		19a. Informant's Name/Relationship (Type, Print) Mrs. Tammy Beaghan (Daughter)	_				Maryland	21222
ore,	the He	Ì	20a. Method of Disposition 1 IXBurial 2 □ Cremation 3 □ Removal from State	ce of Disposition etery, cremato	n (Name of ry or other plac	ce)	Date	20c. Location - City of	Town, State
Baltimore,	permit. Pages Depertment of Important: If it any Injury or o			k Lawn			/2005		e, Maryland
Ba	perm Depe Impo any i		21. Signature of Purietal Service Licensee	A	a-Ruck 2 Wise			Dundalk, Dun	Inc. 21222
	*		23a and Enter the disease of complications that caused the death. shock, or heart failure clast only one cause on each line.						Approximate Interval Between
-	Physician /Medical								Onset and Death
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. END-Superior Superior Sup	as a consequen		COPD)		8 months
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_ <u>r</u>	ificate be executed g physician end as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequen	ce of):				
68760,	ate be hysicia the bur	edicai	Cause (Disease or injury that initiated events resulting in death) Last	s a consequent	ce of):		4 11 11		
	₩ Do es		d						
. Box	death cert e attending ed for use a	Physician/N	Part II. Other significant conditions contributing to death but not resulting	ing in the under	lying cause giv	en in Part I.	23b. Díd	tobacco use contribut	e to the cause of death?
P.O.	requires that the death cer been signed by the attendir hould be deteched for use						埂	Yes 2 No 3 F	Probably 4 Unknown
ds,	uires ti signe	d by							Were autopsy findings
Vital Records,	2 S	Completed					pen	ormed?	available prior to completion of cause of death?
E E	The law i	Com					1 🗆	Yes 2 No	1 ☐ Yes 2 ☐ No
Ĭ;	Physician: The rthis certificate and director, page	9 Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EF	P/Outpatient 1	B□ DOA Oth		ath Check only	one) idence 6 □Other (Spe	ocifu)
of	g Physicarthis	n: To	27. Manner of Death 28a. Date of Injury 28	8b. Time of Injury	28c. Injur Wor			how injury occurred	suryy
sior	Attending I r death, actor: After by the fune	catic	2 Accident investigation			Yes 2□No	39f Location	(Street and Number or F	Rumi Pouto Number
Division	al or Attenos s after deat il Director: ed in by the	Certification:	4 Homicide determined 28e. Place of Injury - At homicide building, etc. (Specify)	e, tarm, street,	tactory, office			wn, State)	urai noule ivulliber,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical (20s Certifier (Check only one) Certifying Physician: To the best of my knowledge (Check only one) Certifying Physician: To the best of my knowledge (Check only one)						
	To the Ho within 24 h To the Fu completel	N N	29b. Signature and title of certifier		29c. Licens			29d. Date signed (Mor	· ·
			· To How	MO	Do	0550	035	8/10/	05
6	x or		30. Name and add ss person who completed cause of death (Item 2:	(Type, Prin	10 12	a 1	RIN	RIL	MO 71718
	Sta	te	31. Date filed (Month, Day, Year) 32. Figistrar's Signatur	re - A.	N -	IVI I	0100	Dolling) -10 -166
	Registr	ar	AUG 1 2 2005	N Agos					
DH	MH 16 Rev 6/95			1					

Linda Makel Unpend item#23a,27,28a-1, perME G847,9/23/05 TT

State of Maryland / Department of Health and Mental Hygiene 05 - 5352AKG 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Physician inda 2005 1:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months Hours Min 1 M 200 10-82-236 Yrs. Director Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside Lity Limits 28a-f show other traumatic syent, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland TMOS 10e. Street and Number 10g. Citizen of What Country? 0 700 238 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Newer Married 2 Married ō Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Bac If Yes, Give Year or Dates: Specify 3 ₩idowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT us retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pete 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 -daughty 20a. Method of Disposition 20b. Place of Disposition (Na Date Depertment of himportant: If Ite any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Narcotic Intoxication /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent oregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an s certificate has l lirector, page 2 s autopsy performed' 2 🗆 No Yes 2 No Yes or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Medical Certification: To XXYes 2 No 1 🗌 Inpatient 2X ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred unk 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of unk 28c. Injury at Work? After 1 Natural 5 Pending s after death. investigation 8/8/05 M 1 ☐ Yes 2 No 2 Accident 6X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 827 W. Lexington 4 Homicide within 24 hours after To the Funeral Dire St. Baltimore, MD found at home Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 9, 2005 M. no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 THE NORE Miking
31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

32. Ressirar's Signature,

AUG 1

2 2005

05-05268 Thomas Mason RJD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stete Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of F <i>rtificate of</i>			giene Reg. No. 2 0 0	5 261.00
**************************************	Physici /Medi		Decedent's Name (First, Middle, La Thomas M. Mason, Jr.	,				2. Date of De Month August		9-Time of Death U
	Examir		4a. Facility Name (If not institution, given University Hospit	,		4b. City, Town, o		ath	4c. County of n/a	Death
	Funeral Director			Sex 7. Ag	e (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		th (9 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Birthplace (State or Foreign Country)
aryland	work		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
ith the M	or 28a-f	Director	MD n/a 10e. Street and Number		Baltimore	10f. Zip Code			10g. Citizen of Wha	14 Yes 2 No at Country?
d 21215-0036 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: if item 27s or 28a-f show important: if item 27 is marked other than "naturel", or item 27 is marked other than you injury or other traumatic event, the Madical Examiner must be notified at once.	by Funeral	11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 1 If Yes, Give Year or Dates:	MA I	Was Decedent of H II Yes, specify Cuba 1 Yes 2 No	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)	USA 14. Race - Black, SpecifyB1	American Indian, White, etc. Lack
Maryland 21215-0036 d 2 should be filed within 72 hours aff	giene. er than "natur . The Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Give	dent's Usual Occup kind of work done DO NOT use retired	eation during most of w d)	rorking	16b. Kind of Busin	•
aryland should be file	nd Mental Hy marked other imatic event,	To Be C	17. Father's Name (First, Middle, Last Thomas M. Mason, Sr. 19a. Informant's Name/Relationship (Mary Turn	er	Maiden Sumame) er, City or Town, Sta	ste, Zip Code)
Nore, Ma	or other tract		Constance Mason/siste 20a. Method of Disposition 1 💆 Burial 2 🗆 Cremation 3	Removal from State		ueengate Rd	l. #29, Ba	1timore, MI		
Baltimore,	Departme Important any injury once.		4 Donation 5 Other (Special Signature of Funeral Service Lice	··		2. Name and Addre	ss of Facility	544X	Randallstow al Hous P.A MD 21217	
\(\bar{\lambda}\)	ysician Medical aminer-transit	edicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	a consequence of):				rrest,	Approximate Interval Between Onset and Death
Records, P.O. Box 68 The law requires thet the death certifical	by the attending physi tached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	f delivery Day Year
rds, P	been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death be	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	V'	te to the cause of death? Probably 4 □Unknown
	ete has page 2	Completed							osy prior rmed? see	e autopsy lindings available to completion of cause of h? Yes 2 . No
ysicie		To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Anpatie	nt 2 ER/Outpatien	t 3 DOA Oth		eath (Check only o	ne) dence 6 □Other (Speciful
٥ و و و	h. Alter this funeral di		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	28c. Injun Worl	y at k?		now injury occurred	
DIVISION Of VITA Hospital or Attending Physicien:	ofter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	0110	ry - At home, farm, str		Yes 2 No	City or Ton	Ject Sty Street and Number of m, State) 600 f hueve	Rural Route Number, 15 Li Dick How St
Hospi	Fur Fur	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Ph	niner: On the basis of	of my knowledge, death examination and/or inv	occurred at the tin	ne, date and place pinion, death occ	e and due to the	cause(s) and manne	or as stated. due to the cause(s)
To the	within 2 To the complete	Me	29b. Signature and title of certifier	Aalla	ind	29c. License O.C.	e number		29d. Date signed (A August 5	fonth, Day, Year)
	2		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print) 111 P	enn Str	eet Balti	more, Mar	yland 21201
	Sta Registr		31. Date filed (Month, Day, Year) AIIG 1 9	32. Redistra	ar's Signature	perti				

		•	For State Registrar	State of Maryland	-	rtment of H			giene Reg. N2 0 0 5	26401
			Decedent's Name (First, Middle, La	st)				2. Date of De	ath	3. Time of Death
	Physicia		Wayne M. Mou	ldor				Month	Day Yea	5 OGUD M
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat	h Ulgus	4c. County of De	path
	Examin	er	Parison La Parison	of solical lea	10-	Salie	-burd		Willen	2110
	Funeral			Sex 7. Age (In yrs. last	t birthday)_	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th 9. B	lirthplace (State or Foreign
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	_		Usual Residence of Decedent					100110		
	rylan how		10a. State 10b. County	10c. City, T	fown or Loc	ation				10d. Inside City Limits
	a-fs	cto	MD Wicomic	o Sal	lisbur	У				1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code	0.1.0.0.1		10g. Citizen of What	Country?
	23a d	ai	1101 Schumacher	Drive			21804		USA	
	ems er	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - Ar Black, WI	merican Indian, hite, etc.
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Ma	교육등학		Margaret Mould	er/spouse	1101	Schumach	ner Driv	e Salisb	ury, MD 2	1804
ē,	Hear Hear tem othe		20a. Method of Disposition	20b. Plac	e of Dispos	ition (Name of atory or other place		Date	20c. Location - City	or Town, State
20			1 ☐ Burial 2 ☐ Cremation 3 ['4 ☑ Donation 5 ☐ Other (Special	_Hemoval from State	<i>ө</i> сөгу, стат	atory or ourier place	e) : 			
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Ba	permit. Page Department of Important: If any injury or once.		Ronald S	Wade, Director	Sta	ate Anato	omy Boar	d ₁ 655 W.	Baltimore	Street
	-		23a. Part 1 Enter the disease, or con	nplications that caused the death.		ltimore, rthe mode of dying		c or respiratory a	rrest,	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		11				Interval Between Onset and Death
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		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequen		9	7			Years Year
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Corona	ry c	arten	diene	CP		Years
Ć,	exector and and ial-tra	Еха	resulting in death) Last	Due to (or as a consequen		7	(2)	1.0		
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Вох	eath certifi attending I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		Ectopic pregnancy			23d. Date of c	•
	deatl e atte	icia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of deat		Other (specify)			Month	Day Year
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ğ	w require been sig		Viabetes 1	hellitus typ	2e 4			1 🕒	Yes 2□No 3□	Probably 4 Unknown
Records,	aw re is be	Completed						24a. Was		autopsy findings available to completion of cause of
	The law ate has page 2 :	mo							ormed? death	?
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>	Physician: this certificanal director,	To B	examiner?	Hospital: 1 Denpatient 2 EP	R/Outpatient	3□ DOA Oth	er: 4 🗌 Nursing	Home 5 Res	idence 6 Other (S	pecify)
υot			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	8b. Time of Injury	28c. Injun Worl	y at k?	28d. Describe	how injury occurred	
<u>i</u>	ttendir death. ctor: Af y the fur	atic	2 Accident investigation	on			Yes 2 □ No			
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edicai	(Check only 2 Medical Exa	Physician: To the best of my knowled iminer: On the basis of examination	edge, death n and/or inv	occurred at the time estigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time.	cause(s) and manner date and place, and c	as stated. lue to the cause(s)
	the the	Med	one) 29b. Signature and title of certifier	and manner stated.		29c License	e number		29d. Date signed (Mo	onth, Day, Year)
	To Yell		200. Signature and title of certifier	1 2 2		1 Donates	00010		8/8/	(, /,
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			30. Name and address of person who	completed cause of death (Item 2)	(Type, F	rint)	Sall		21901	
			31. Date filed (Month, Day, Year)	de 100 Ept	-and	Misteet	ופטוורב	ing Ma	वाक्षा	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 1 2 200	o ocripleted cause of death (Item 2:	Good	2				
				/S	-					

Wayne Moulder

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8 Day Month AUGUST **Physician** 2005 LILLIAN MCLAUGHLIN 12:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris, Inc. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug 28, 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2√F 87 Director Yrs. 215-07-8535 1917 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nat: If them 27 is marked other than "natural", or thems 23e or 28a-1 show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 27 Is marked other than "natural", or Items 23e or 28a-f show traumatic event, Ita Madical Evant at must be notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2614 Canterbury Road 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Reynolds Sara Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Molly Quinn/daughter 2614 Canterbury Road Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If It any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board
Thore, MD 21201 21. Signature of Funeral Service Licensee

Ronald S. Wade 655 W. Baltimore Street Baltimore, MĎ Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month 4 Pregnant at time of death 5 ☐ Other (specify) signed by the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an was a... autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 5 Pending Natural death. 1 Yes 2 No investigation 2 Accident after death Director: 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signatur

ERNESTINE WRIGHT,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Osborne 9, Raymond Allen 9:05 A August 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Co. Eastpoint Nursing Home Eastpoint If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**∑**M 2□ F 73 Yrs. 9,1932 Director Maryland Jan. 213-62-2324 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in then "natural", or Itema 23s or 28s-f ehow the Medical Exeminer must be notified at 1 ☐ Yes 2X No Eastpoint Baltimore Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21224 1046 Old North Point Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2≦ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1X Never Married 2 ☐ Married Itimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Dependant N/A10 Years nd 2 should be filed atth and Mental Hygic 27 is marked other recematic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dale A. Osborne Sylvia C. Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 I Mrs. Sandra Pozdena (Sister) 5483 Glenthorne Ct. Rosedale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State partment of cortaints if 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 8/12/2005 Baltimore, Maryland permit.
Departr
Imports
eny Inji 21. Sign Hure of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 21222 7922 Wise Ave. Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) suatur **Physician** /Medical Due to (or as a consequence of) Examiner MSPhages S ... uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequarce of): Examine attending physiclen and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No P.O. the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No s certificete hes t lirector, page 2 s or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 Z-No 1 Yes this After thi funeral 28c. Injury al Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier. 300/1150 12005 30. Name and address of person who completed cause of death (Item 23a) (Type Print) SELLWOOD AVE BALTO MD 21224 TORRES, MO 441 M. 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar 2005

			for State Registrar	Sta			d / Depa		t of H	ealth a	and M	fental Hy	gien	-		20101
			Decedent's Name (First, Middle)	dle, Last)								2. Date of De		-UU	J	3. Time of Death
	Physici		Mary A. Payn	е								Aug.	9,	2005	Year	18:19P ^M
3	/Medic Examin		4a. Facility Name (If not institution		and number))		4b. City,	Town, or	Location	of Death			c. County	of Death	10.191
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	Funeral		5. Social Security Number	6 Sev	7 1	ge (In yrs. la	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bi (Month, D			9. Birth	place (State or Foreign
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Σ	1 and 2 Health a lem 27 is		Edward M. Payn	.e (i	Son)		1911	Hick	ory	Lane	Sil	ver Spi	ring	Md.	2090	06
ē,	the the state of Heal item		20a. Method of Disposition			20b. Pla	ace of Dispo	sition (Nan	ne of	a)	ľ	Date	20c. L	ocation - (City or To	own, State
E	Page nent nt: If		X1X Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (al from State	Wasi	hingto	n. Na	tior	nal i	Aug.	18,105	Su	itlar	nd, N	ID .
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<u>o</u> .	t the de by the a tached f	/sic	1 ☐ Yes 2 DXNo 9 ☐ Unknown		⊒Pregnant a ⊒Unknown	at time of de	ath 5□	Other (spe	ecify)					101011		Duy Tour
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	Physici /Medio		Decedent's Name (First, Middle Dorrothy Jane								2. Date of I Month AUGUS	D	ay 1,20	Year 05	3. Time of Death	М
	Examir	er	4a. Facility Name (If not institution GREATER BALTI	MORE MED	ICAL CE		TOW	ISON	Location of			В		of Death		
	Funeral Director		5. Social Security Number 233–32–4710 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🛣	7. Age (In y	rs. last birthday Yrs.) If Under Months	Days	If Under Hours	Min.	8. Date of E (Month, I March	Birth Pay, Year 15, 19	24	9. Birth	place (State or Forei intry)	gn
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Baltimore,	957 = 9		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3		om State	b. Place of Dispo cemetery, cre foreLand I	position (Name matory of other Mem. Par	e of her place LK	9)	Aug.	15 , 2005		ocation -	-	own, State	
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8760,	Cate be executed / Medical Examiner in the burial-transit	dicai Examiner	23a/Part T. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that initiated events resulting in death) Last	a	- A.	sequence of):	ter the mode	e of dying	g, such as	cardiac c	or respiratory	arrest,			Approximate Interval Between Onset and Death	
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	1⊜Liv 4⊜Pr	outcome of pre- re birth 2 Fegnant at time of the contract of	etal death 3	⊒Ectopic pre □ Other (spe						23d. Dai Mo	te of deliventh	ery Day Year	
rds, P	quires that n signed b uld be deta	ed by PI	Part II. Other significant conditi	ons contributing t	o death but not	resulting in the u	inderlying ca	use give	n in Part I.		11	tobacco			he cause of death?	n
al Records,	(i) we	Completed										opsy formed?		Were auto prior to co death?	ppsy findings available mpletion of cause of	ө
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ※ No	Hospital	MInpatient 2	ER/Outpatie	nt 3□ DO/	Otho			re 5 ☐ Re		e Coth	or /C=+=i		
ion of	ding After fune	ation; T	27. Manner of Death 1"⊠Natural 5 ☐ Pendi	28a. Da	ite of Injury fonth, Day Year	28b. Time o		Ic. Injury Work	at	2	28d. Describe				y)	
Division	al or Atte s after des al Diracto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Pl	ace of Injury - A ilding, etc. (Spe	t home, farm, sta ecify)	reet, factory,	office		2	28f. Location City or To	(Street a	nd Numb e)	er or Rura	al Route Number,	1
	To the Hospitel or Attending Physicien: Within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	Medicai (29a. Certifier 1 S Certifyi (Check only 2 Medical one)	ng Physician: To Examiner: On th and m	the best of my lee basis of exam anner stated.	knowledge, deat ination and/or in	h occurred a vestigation.	t the time in my opi	e, date and inion, deat	d place, a	and due to the	e cause(s e, date an	and ma d place, a	nner as s and due to	tated. o the cause(s)	
)	With:	W	29b. Signature and title of certifie	M.D.				License	number	-				(Month,	Day, Year)	
	17		30. Name and address of person Rekha Mota	who completed c	ause of death (I	tem 23a) (Type,	Print)	stre	et	Bn	ltim	ru,	nD	212	04	
	Sta Registr	. · · · · · · · · · · · · · · · · · · ·	31. Date filed (Month, Day, Year, AUG 1	2 2005	. Registrar's Sig	gnature	and is									

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	4	For State	ease Type or Pri State of M		Depar	tment of H	lealth and M			egible.	
	1	Registrar			Cert	ificate of	Death		Reg. No.	UQ5	2640
Physicia		1. Decedent's Name (First, M	Iddle, Last)		Pro	Lino		2. Date of De	eath Day	Year	3. Time of Deat
/Medica		1a Facility Name (If not inciting	ution, give street and number,	1	140		r Location of Death	<i>.</i>	40.00	2005 Junty of Deat	1 Q.J. H
Examine		BALTIMORE 5. Social Security Number	VA Medical	Cent	ter	BALT If Under 1 Year	MURL If Under 24 Hrs.	8. Date of Bir	th	NIA	hplace (State or Fore
rector		216-20-2981 Usual Residence of Deceden	1 🗹 M 2 🗆 F	79	Yrs.	Months Days	Hours Min.	(Month Da	/1925	Co	untry)
Mon	-	10a. State 10b. Cou		10c. City, To	wn or Loca	ition					10d. Inside City Lim
or 28a-f show	į	PA Yor	k	Dover							1 ☐ Yes 2 ☑
or 28	<u>i</u>	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Co	untry?
1	ie	3156 Lion Cou	rt			17315			Unite	d Stat	ces
Important: if item 27 is marked other than "natural", or items 23e of 28e4-shov any injury or other traumatic event, the Medical Evantinar must be notified at pnce.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ 1	If Yes Give	? No	If '	as Decedent of Hores, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		. Race - Ame Black, White pecify: Whi	e, etc.
al Ex	ğ D	3 ☐ Widowed 4 ☐ Divor			D. D.	-M-1110	- At a li		,		
De Media	Completed	(Specify only his Elementary/Secondary (0-1	dent's Education ghest grade completed) College (1-4or	5+)	(Give ki	NOT use retired	during most of worki	ng	1	of Business/	•
Dit.		17. Father's Name (First, Mid	die, Last)				18. Mother's Name	(First, Middle	, Maiden Su	umame)	
COV	To Be	Dominic Paol	ino				Elizabeth				
traumat		19a. Informant's Name/Relati			-		and Number or Rura		-	own, State, 2	Zip Code)
other	ŀ	20a. Method of Disposition	AMILE	20b. Place	of Disposi	ion (Name of	, [ate		tion - City or	Town, State
y or	ï	1 ☐ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe	ion 3 □Removal from State or (Specify)	•		tory or other place. Cremat.	ory Inc. 2	ug 10	Belts	ville,	Maryland
Importar any injur once.	ŀ	21. Signature of Funeral Sen		011000	22.	Name and Addre					-
ysician ledical aminer	er	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	e, or complications that cause List only one cause on each a. Due to or as	eN41 s a consequence mpL	Final Final	4: Lur			rrest,		Approximate Interval Betwee Onset and Dea
	Exa	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a consequenc	ce of):						
y the attending physic	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Live birth	e of pregnancy 2 Fetal dea at time of death		ctopic pregnancy Other <i>(specify)</i>	1		230	d. Date of del Month	ivery Day Year
been signed by the should be detached	d by Pr	Part II. Other significant con	ditions contributing to death	but not resulting	g in the und	erlying cause giv	en in Part I.		obacco use Yes 2 □ I		the cause of death
2 2	Completed							24a. Was auto perfo 1 1 Yes	an psy promed? 2 No	death?	itopsy findings avail completion of cause
tor. p	a a	25. Was case referred to me	dical				26. Place of Death			1 103	2010
direc	ToB	examiner? 1 Tyes 2 No	Hospital: 1 X Inpat	ient 2 🗆 ER/0	Outpatient	3 DOA Oth	er: 4 Nursing Ho	me 5 ☐ Resi	dence 6 [□Other (Spe	cify)
After this funeral di		27. Manner of Death 1 ▼Natural 5 □ Pe	restigation	ury 28b ay Year)	o. Time of Injury	28c. Injur Wor M 1	y at k? Yes 2 □ No	28d. Describe	how injury o	occurred	
9 9	atic							28f. Location /	Street and I	Vumber or Ru	
al Director: ed in by the	Certification	3 ☐ Suicide 6 ☐ Co	termined 28e. Place of Ir building, e	njury - At home, tc. (Specify)	farm, stree	t, factory, office		City or To	wn, State)		ıral Route Number,
na Funeral Director: sletely filled in by the f	edicai Certification;	3 Suicide 6 Cc de 4 Homicide de 29a. Certifier 1 Cert	termined 289. Place of Ir	t of my knowled	ige, death o	occurred at the tir	ne, date and place,	City or To	cause(s) ar	nd manner as	stated.
al Director: ed in by the	edicai	3 Suicide 6 Ccd de 4 Homicide 29a. Certifier (Check only 2 Medi	ifying Physician: To the besical Examiner: On the basis and manner s	t of my knowled	ige, death o	occurred at the tir stigation, in my o	ne, date and place, a	City or To	cause(s) ar date and pl	nd manner as lace, and due signed (Monti	stated. to the cause(s) h. Day, Year)

			For State	State of M		nd / Depa	artment of	Health and I	•	/gien	e	
	40	40	Registrar 1. Decedent's Name (First, Middle, Las			Cei	tificate of	Deam	2. Date of D		2005	
	hysicia /Medic		Gladys V. Phaneu	•					Month	D	11,200	
- C- C- C- C- C- C- C- C- C- C- C- C- C-	xamin		4a. Facility Name (If not institution, give)		4b. City, Town,	or Location of Death			c. County of D	-7
Salar Salar	#1 B	ાં .	St. Agnes Hospit				Baltimo				/a	
	neral ector			9x		iast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, D 06-16-	1910	9. E Ma	Birthplace (State or Foreign Country) aryland
and	A to		Usual Residence of Decedent 10a. State 10b. County	-	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
Mary	3	ţō	MD Howard			Lcott (1 ☐ Yes 2 ☐ No
the	Light I	lrec	10e. Street and Number				10f. Zip Code			10g. C	itizen of What	Country?
death with the Maryland	238	aD	3004 N. Ridge Rd.				21042			U.S	.A.	
rdea	or tema	Iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13. \	Vas Decedent of	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or N	0-	14. Race - A	merican Indian,
36 afte	2 4	Y FL	1 ☐ Never Married 2 ☐ Married 3 🚰 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give			☐ Yes 2☐ No		7			
90 Pont	E E	g pa	15. Decedent's Ed	Year or Dates:			lent's Usual Dccu			101	V	Thite
1215-0036 within 72 hours atter	led Sed	plet	(Specify only highest gra-	de completed)		(Give	kind of work done OO NOT use retire	pation during most of worked)	ang	160.1	Kind of Busine	ss/Industry
21215-003 ad within 72 hours, giene.	4	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or	5+)	Switc	h Board	Operator		C &	P Tele	phone Co.
Ind 2	vent vent	Be	17. Father's Name (First, Middle, Last) Herman E. Waltemy	er				18. Mother's Nam				
Maryland 2.2 should be filed v	atic a	2						Lillie S				
Maryland d 2 should be fliet th and Mental Hy	in tem 27 ie marked other then "nature", or tema 23e or 28e-i enow or other traumatic event, the Modical Examinar must be notified at	İ	19a. Informant's Name/Relationship (7 Shirley E. Charlt		or			t and Number or Rui				o, Zip Code)
ore, M	ther	}	20a. Method of Disposition					Lane Wood	Dine, M			or Town, State
Mor Pages	yord		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				sition (Name of natory or other pla rematory		2-2005		ltimore	
Baltimore, permit. Pages 1 a	eny Injury or conce.	}	21. Signature of Funeral Service Licens		0/						LCIMOTE	, MD
- n ad	eny l		* Daniello	Maush	ex	A	mbrose F 328 Sulp	ess of Facility Uneral Ho hur Sprin	me, Inc g Rd. A	:. rbut	tus MD	21227
			23a. Part 1. Enter the disease, of comp shock, or heart failure. List only	lications that caused one cause on each li	the dept	h. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
Phys	ician		Immediate Cause (Final disease or condition	Recu	RAC	KTC		ROVASCO			dense	Onset and Death
TAY IN THE RESERVE OF THE PARTY	dical niner		resulting in death)	Due to (or as	a conseq	uence of):	4					60495
		_	Sequentially list conditions.	b. Keff		TORY	ATRI	Altib	RILLAT	TON		10 years
E 5	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C P R	ON	2.1	hear	z = d, 0	CASO	0		30.000
760, Figure 1900 and	burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as	- '		VI CATI	C/ Q/3	CHS			20 YEARS
~ 0 9	a par	ca	(d								
Division of Vital Records, P.O. Box 68 for Attanding Physician: The law requires that the death certificat effect deeth.	for use as the	Physician/Med	IF FEMALE:									
BO ath ce	or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Feta	death 3	Ectopic pregnanc	y			23d. Date of o	lelivery Day Year
O 84 8	detached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of di	eath 5	Other (specify) _				WOITH	Day 16a1
rhatt	deta		Part II. Other significant conditions co	intributing to death b	ut not resi	ulting in the un	derlying cause gr	ven in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
rds quires	should be det	Completed by		Gemic	-		dise	ASC	1 🗆	Yes 2	₩o 3□	Probably 4 Unknown
O ME	2 sho	olete	FOCAL [MO	ACTION	/				24a. Was	an	24b. Were	autopsy findings available
The li	заде	E	1 · · · · · · · · · · · · · · · · · ·						auto perfo	ormed?	prior to death	o completion of cause of
in in in in in in in in in in in in in i	director, page	Bec	25. Was case referred to medical examiner?		/			26. Place of Deat			, , , ,	2010
of V hysic	al dire	ᄋᆝ	1 Tes 2 No			ER/Outpatient		4 Nursing Ho	me 5 🗆 Resi	dence	6 □Other (Sp	pecify)
O' Ging F	funeral	0	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Inju- (Month, Day	ry y Year)	28b. Time of Injury	28c. Injui Woo		28d. Describe	how inju	ry occurred	
Vitano Attano deetl	y the	lica	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	urv - At ho	me farm stre		Yes 2 □ No	28f Location /	Street as	nd Number of	Rural Route Number,
Div	ed in b	Certification:	4 Homicide determined	building, etc	c. (Specify	()	or, ractory, office		City or To	wn, State	9)	nulai noble Numbel,
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours effect deeth.	completely filled in by the	Medical	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of and manner sta	examinal	wledge, death tion and/or inv	occurred at the til estigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s date and) and manner d place, and d	as stated. ue to the cause(s)
Tota	E com	Σ	29b. Signature and title of certifier	\ \ \	2/12	.10	29c. Licens	_		-	_	nth, Dey, Year)
			- Cultan) ATTE	ph	VSICII	m (1620	0	AU	GUST	11,2005
- V	\		30. Name and address of person who co		eath (Item	23a) (Type, F — M A I	Print) DEN C	hoicelt	A. CA	TOL	osville	11,2005
R	Stat egistra	_	31. Date filed (Month, Day, Year) AIIG 1 9 20	32 Registra	ar's Signa		we					

		State Registrar		Maryland /		ificate of l			Reg. No.	005	26408
hysicia	_	1. Decedent's Name (First, Midd		1100 =	2			2. Date of De Month Auq.	aath Day 10	2005 5	3. Time of Dealh
/Medica		4a. Facility Name (If not institution		ALOM [3 nber)		4b. City, Town, or	Location of Dea			County of Dea	
		6701 Highview				Overl				altimo	
neral ector		5. Social Security Number 025~20~0B11 Usual Residence of Decedent	6. Sex X⊠M 2□F	7. Age (In yrs. last i	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		av. Year)	9. Bin Co Ma	thplace (State or Forei ountry) BSS.
ust be notified at		10a. State 10b. Count	timore	10c. City, To		ation timore C	ounty				10d. Inside City Limit
Pe nel	Funerai Director	10e. Street and Number 6701 Highview	Avenue			10f. Zip Code	21206			zen of What Co	ountry?
ms 23	erai	11. Marital Status	12. Was Dece	dent Ever in U.S.	13. W	as Decedent of H Yes, specify Cuba	spanic Origin? (Specify Yes or N		USA 14. Race - Ame	
0,0	ρ	1 Never Married 2 Na 3 Widowed 4 Divorce	Armed For 1XXVes If Yes, Giv. Year or Da	ces? 2 □ No e WW 11 tes: WW 1		Tes, specify Cuba	Specify:	no Rican, etc.)	i	Black, Whit Specify: Wh	
u H	ietec	(Specify only high	ent's Education nest grade completed)		6a. Decede (Give k life. De	ent's Usual Occupi ind of work done of O NOT use retired	ation during most of wo	orking	16b. Kir	nd of Business	/Industry
other then	Completed	Elementary/Secondary (0-12) 12 yrs.	3 yrs.	-4or 5+)		Intelli	jence		J	. Gover	nment
event.	Be	17. Father's Name (First, Middle Dominic Palom						me (First, Middle Chiocio		Sumame)	
marke	2	19a. Informant's Name/Relation		1	9b. Mailing	Address (Street				Town, State,	Zip Code)
or treu		Bernadine R.			-	lighview			-		
Importent: If item 27 le marked oth any Injury or other treumetic even once.		20a. Method of Disposition Y☐Burial 3 ☐ Cremation	a 3 □Removal from 5	State ceme	etery, cremi	ition (Name of atory or other place		Date		cation - City or	
njury njury	r	4 □ Donation 5 □ Other (21. Signature Funeral Service	(Specify)	Parkw		Cemetery		5~2005	ватт	timore,	Ma.
any l		1 1/ Olives	4/000	16		Name and Address Lassann 7401 Bel	⊢uneral air Rd.	Home Baltimo	re, M	ld. 212	36
		28a. Part . Enter the disease, shock, or heart failure. Li	or complications that crist only one cause on e	aused the death. Dach line.							Approximate Interval Between
ician	-	Immediate Cause (Final disease or condition		RNIAC 1)45K	Huthmi	A				Onset and Death
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g physicien as the buria	ledicai		in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Ves 2 No. 4 Pregnant at time of death 5 Other (specify)							23d. Date of de	livery
attending for use a	ysician/Medica	23b. Was decedent pregnant in the past 12 months?	1 Live b	irth 2 Fetal dea ant at time of death	ath 3 □					MOHIII	Day Year
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Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a	To Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1	titions contributing to de ASCULAR Hospital: 28a. Date ding stigation Id not be mined	irth 2 Fetal deant at time of death own eath but not resultin DISEAS E	ath 3 in 5 in 5 in 5 in 5 in 5 in 5 in 5 in	Other (specify) derlying cause giv 3	en in Part I. 26. Place of Doer: 4 \(\text{Nursing} \) \(\text{v} \)	24a. Wa auth per 1 1 Yes eath (Check only Home 5 Res 28d. Describe	Yes 2[s an oppsy or med? 2[No one) sidence 6	se contribute t No 3 P 24b. Were a prior to death? 1 Period of the Control of t	o the cause of death? robably 4 Unknow utopsy findings availat completion of cause of s 2 No
Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a	Certification: To Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1	titions contributing to de ASCULAR cal Hospital: 1	inth 2 Fetal deant at time of death own eath but not resultin	ath 3 in 5 in 5 in 5 in 5 in 5 in 5 in 5 in	Other (specify)	26. Place of Does: 4 Nursing yat k? Yes 2 No	24a. Wa autuper 1 Yes eath (Check only Home 5 Res 28d. Describe 28f. Location City or Tope, and due to the	s an appsy corned 2 No one) sidence (street ann, State, er cause(s)	se contribute t No 3 P 24b. Were a prior to death? 1 Yes 6 Other (Spery occurred) d Number or Fi	o the cause of death? robably 4 Unknov utopsy findings availat completion of cause of s 2 No ecify) rural Route Number, s stated.
he Funeral Director: After this certificate has been signed by the attending pletely filled in by the funeral director, page 2 should be detached for use a	To Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1	itions contributing to de ASCULAR cal Hospital: 1 1 28a. Date of (Mont) stigation ld not be rmined 28e. Place buildi ying Physician: To the ball Examiner: On the ball Examiner:	inth 2 Fetal deant at time of death own path but not resulting path but not	ath 3 in 5 in 5 in 5 in 5 in 5 in 5 in 5 in	Other (specify) derlying cause giv 3 □ DOA Oth 28c. Injur Wor M 1 □ et, factory, office occurred at the tire estigation, in my of	en in Part I. 26. Place of Doer: 4 \(\text{Nursing} \) y at k? Yes 2 \(\text{No} \) No	24a. Wa autuper 1 Yes eath (Check only Home 5 Res 28d. Describe 28f. Location City or Tope, and due to the curred at the times	s an opsy of the post of the p	se contribute t No 3 P 24b. Were a prior to death? 1 Yes 6 Other (Spay occurred) and manner a place, and du	o the cause of death? robably 4 Unknow utopsy findings availat completion of cause of s 2 No ecify) tural Route Number, s stated, e to the cause(s)

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ven	Charle	S	1 - State Amena Item 20 Registrar	State of Maryland / Dep & Unpend Item 23a	artment of I Triffeate of	George G846 8	-22-05 tas Reg. N	2005	26409
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Steven Charles Pan	te		M	ate of Death Ionth D gust 06	,2005 Year	3. Time of Death 1343 M
	Examir		4a. Facility Name (If not institution, give s	treet and number)		or Location of Death	4	c. County of Death	
			2301 Reliance Ct. 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday		ttsville	ate of Birth	Harfor	
	Funeral Director			M 2□F 23 Yrs.	Months Days	Hours Min. (A	n. 30,	1982 Mar	place (State or Foreign ntry) yland
	Maryland -f show)r	10a. State 10b. County	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2√€ No
	28a-f	Funeral Director	Md. Harford 10e. Street and Number	Bel	. Air 10f. Zip Code		10g. C	Citizen of What Cou	
	death with the ms 23a or 28a rmust be noti	ח	917 Whispering Ric	lge Lane		21015		J.S.A.	,
	death	nera				Hispanic Origin? (Specify Yoan, Mexican, Puerto Rican		14. Race - Amer	
036	hours after death with the Marylan turel', or Items 23e or 28e-f show el Exantrer must be notified at	by	1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No		, etc.)	Black, White	
5-0	72	eted	15. Decedent's Educ (Specify only highest grade	cation 16a. Dec	edent's Usual Occu	pation during most of working	16b.	Kind of Business/Ir	ndustry
21215-0036	within Bne. than	Completed	Elementary/Secondary (0-12) 12 years	College (1-4or 5+) life.	DO NOT use retire	od)	wai	cehouse	
pu	be filed ntal Hygid of other event, I	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (Firs		,	
yla	Ment Ment arke	T _o	Roger C. Pare			Patricia A			
Maryland	i 2 sh h and 7 is m reum		19a. Informant's Name/Relationship (Type Patricia A. Pare/		-	t and Number or Rural Rou ng Ridge Lan			
e,	es 1 and 2 should be fi of Health and Mental H Item 27 is marked of r other traumatic ever		20a. Method of Disposition		osition (Name of omatory or other pla		-	Location - City or T	
Baltimore,	Pag nent ant: I		1 ☐Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Bel Air	Mem. Gdn	s. 8/10/20		l Air, Mo	
Bai	Departr Departr Importu any Inju		21. Signature of Funeral Service License		Schimune Schimune	ess of Facility k Funeral Ho	me of B	el Air,]	inc.
8			23a. Part1. Enter the disease, or compli	cations that caused the death. Do not er	610 W. M	acPhail Road	Bel A	ir, Md.	21014 Approximate
	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	done Intoxic			Interval Between Onset and Death		
	Examiner	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):					
,09	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
9289		edical							
.O. Box	at the death certificate by the attending physistached for use as the I	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnand □ Other (specify) _	zy		23d. Date of deliv Month	rery Day Year
of Vital Records, P	gned goded	by	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause gi	ven in Part I. 2	23e. Did tobacco	h /	the cause of death?
Ö	aw requir is been si 2 should I	Completed				2	24a. Was an		opsy findings available
R	The lay ete has page 2	E o					autopsy performed? Yes 2 ☐ N	death2	ompletion of cause of 2 No
ita	iclan: Th certificete rector, pag	Bec	25. Was case referred to medical examiner?			26. Place of Death (Che		10 100	
> _	Physic this ce al direc	To	1 X Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA	her: 4 Nursing Home	5- ∏,Po sidence	6 Other (Speci	^{fy)} Scene
ion	ding I	atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury For(Modin, Day Year) 8-6-05 28b. Time Forthid 10:30	Wo	ny at 28d. E ork?]Yes 2 X INo	Describe how in	jury occurred	unk
Division	P in it is	Certification:	3 ☐ Suicide 6 ♣ Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify) House	treet, factory, office		ocation (Street a City or Town, Sta		al Route Number. Liance Ct.
	Hospital 24 hours e Funeral i etely filled	edicai (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my knowledge, deater: On the basis of examination and/or i and manner stated.	ith occurred at the t nvestigation, in my	me date and place and d	ue to the cause	(s) and manner as	stated. to the cause(s)
_	To the within 2 To the comple	Me	29b. Signature and title of certifier	. P	29c. Licen	se number	29d. E	Date signed (Month	Day, Year)
			Mayrie Vh	e While own	OCM	Œ	A	ugust 07,	2005
			30. Name and address of person who co	4		D 1.	3.5	_1 . 1 040	101
			31. Date filed (Month, Day, Year)	32. Strar's Signature	renn Str	eet, Baltimo	re, Mar	yrand 212	OT
13	Sta	te	NIC1 9 201	AND THE RESERVE OF THE PERSON	A				

DHMH 17 Rev 1/2001

AUG1 2 2005 Busine & Marile

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Decedent's Name (First, Middle, Last	,				2. Date of Death Month	Day Year	3: Time of Death
					August		8:12 P M
Social Security Number 6. S	ex 7. Age	e (In yrs. last birthday 48 Yrs.	/ If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Ye	9. Birth	place (State or Foreign
Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
MD		Baltimo	re				1 ZYes 2 □ No
10e. Street and Number		Durcino	10f. Zip Code		10g.	. Citizen of What Cou	untry?
3612 E. Fayette	st.		21224			USA	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?		Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ofy Yes or No- ican, etc.)	Black, White	. etc.
(Specify only highest gra	ide completed)	(Giv	e kind of work done di	uring most of working	g 16t	b. Kind of Business/I	ndustry
9th	College (1-401)		orer		Ur	nknown	
				18. Mother's Name	(First, Middle, Mai	iden Sumame)	
	Type, Print)		- 100				
1 Burial 2 Teremation 3		Bayview	Cremato	ry 8/9/	05 Du	ındalk, M	MD
21. Signature of Funeral Pervice Lice					_		
Justing Ch	any						31 Approximate
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c.	a consequence of): a consequence of).	aruiovascu	Ital Disea	SC		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown	2 Fetal death 3 time of death 5	Other (specify)			23d. Date of delin Month	very Day Year
		ut not resulting in the	underlying cause give	n in Part I.		, ,	the cause of death?
						d? prior to o	opsy findings available ompletion of cause of
25. Was case referred to medical examiner?					(Check only one)		
1 X Xes 2 No 27. Manner of Death 1 A Natural 5 Pending	28a. Date of Injui (Month, Da)	ry 28b. Time	of 28c. Injury Work	at 28			rfy)
3 Suicide 6 Could not be determined	286. Place of Inju	ury - At home, farm, s c. (Specify)	treet, factory, office	28			ral Route Number,
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exert	niner: On the basis of	examination and/or i	th occurred at the time nvestigation, in my op	e, date and place, ar inion, death occurred	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
29b. Signature and title of certifier	nelkrel	e m	O.C.				
30. Name and addre is of person who	completed cause of d						
	4a. Facility Name (If not institution, given Franklin Square 5. Social Security Number Unknown Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number 3612 E. Fayette 11. Marital Status 12 Never Married 13 Widowed 4 Divorced 15. Decedent's Extended (Specify only highest grave) Elementary/Secondary (0-12) 9 th 17. Father's Name (First, Middle, Last, Franklin R. Pal 19a. Informant's Name/Relationship (Reneal Palm 20a. Method of Disposition 1 Burial 2 Cremation 3 A Donation 5 Other (Specify only highest grave) 21. Signature of Funeral Pervice Lice 22a. Part 1. Enter the glease, or common shock, or heart filure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of Alcohol and Methal 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of Alcohol and Methal 25. Was case referred to medical investigation of Check only only investigation of Check only only only investigation of Check only only only investigation of Check only only only investigation of Check only only investigat	Unknown Usuel Residence of Decedent 10a. State 10b. County MD 10e. Street and Number 3 612 E. Fayette St. 11. Marital Status 12. Was Decedent: Armed Forces of Payer o	48. Facility Name (If not institution, give street and number) Franklin Square Hospital 5. Social Security Number Unknown 5. Social Security Number Unknown 6. Sec. Unknown 10b. Clipy, Town or telephone MD 10c. Clipy, Town or telephone MD	## Facility Name (If not institution, give street and number) FrankLin Square Hospital Rosedale	## Ab. City, Town, or Location of Death FrankLin Square Hospital ## Social Security Number Social Security Number S	At Solity Town or Location of Daath Pranklin Square Hospital Social Security Number Unknown 100 County Baltimore 100 County Baltimo	## Aprilly Name (For any applicancy or a transmit and number)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month SYBIL ph POLITAISKY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth JULY 11, 1923 Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🔽 F 215-16-3144 82 Director Usual Residence of Decedent filed withIn 72 hours after deeth with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. State r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ¥ Yes 2 □ No Director BALTIMORE N/A 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2434 W. BELVEDERE AVENUE 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify: Completed by 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR REAL ESTATE permit. Peges 1 and 2 should be filed to Depertment of Heelih and Mental Hygies important: if item 27 is marked other it eny injury or other treumatic event, this once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KOLKER **JACOB** RUTKIN MARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6612 WICKFIELD ROAD - BALTIMORE, MD 21209 RHODA RICHMOND / SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY 08/11/2005 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Phlumma /Medical Due to (or as a consequence of): Examiner T Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and s the burial-transit stage HEMENTIA Due to (or as a consequence of): by Physician/Medical 98 guipi 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No atten for u 3 Ectopic pregnancy Year Month Day 5 Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 9 ☐ Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 TNo 3 ☐ Probably 4 ☐Uлknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 2 2 No 1 Yes 2 No 1 🗆 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 44 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 은 2 ER/Outpatient 3 DOA : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 Yes 2 No within 24 hours after death To the Funerel Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide transfer of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Humotun Venn 8/10/05 D0063327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Belvedere Are, 21215 MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2005 Registrar AUG 1

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

Division of Vital

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Amend item#25, perME, G846, 8/11/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** ingelo 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balthmore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Baltimore Medica A enter 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 217-05-4377 Director Yrs October 12, 1917 MD 87 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If liem 27 is marked other than "natural" any injury or other traumatic average. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Completed by Funeral Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2319 East Fayette Street 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Metal 12 years Tool Dye Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Guiseppina Glorioso Guiseppe Russo ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3022 Dunglow Road, Dundalk, MD. 21222 Philomena Goray sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 1, 20c, Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2005 Holy Redeemer Cemetary Baltimore, MD. * 4 ☐ Donation 5 ☐ Other (Specify) ^{22 Name and Address of Facility}
Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Complications etnic totalfo WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 2 \(\text{No.} 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) XXYes Other: 1 -thpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 -Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 710 · LUZO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State 2 2005 AUG 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#4b, 25, 27, 28a-f, permE, G846, 8/11/05 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Jeannette 2005. Wel. /Medical 1010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3310 HARI-ORL (ONO WINGO Street If Under 24 Hrs. Age (In yrs, last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 200 F Days Hours Months -24-6131 Director MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director HARFORL MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33/0 USA Was Decedent Ever in U.S. Armed Forces? Funeral filed within 72 hours after death Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fill ment of Health and Mental H tent: If item 27 Is marked ott ဥ SAMES Hewart Kei inold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 ls 3310 Conowingo nd. other 20c. ocation - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ŏ ' 4 □Donation 5 □ Other (Specify) Elkton MA Cencolec 21. Signature of Funeral Service Licensee 22. Name and Address of acility BALTI MORE, NID 21234. any in EVANS FUNERAL CHAPEL, 8800 HARFORD RP junule 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Walnutri Physician /Medical Examiner Sequentially list conditions, flary, loading to infractions cause. Enter Underlying Cause, Obsease or injury that initiated events resulting in death) Last Examine consequence of): sicien and burial-transit The law requires that the death certificate be executed CERTIFICATION AV T. VED BY MEDICAL EXAMINE P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery atten for u 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 20 No 1 Yes 2 No 1 ☐ Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2010 To 3 DOA ō 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After Division To the Hospitel or Attending 1 ENatural 5 Pending death. 1 ☐ Yes 2 🛣 No investigation April 2005 2 XAccident unk subject fell within 24 hours after death

To the Funerel Director:
completely filled in by the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 3310 Conowingo 4 Thomicide At home Road, Street, MD 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D-15994 7-13-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 S - UNION AVE -5. GALVEZ GRACE HOURE DE LETICIA m.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		-	For State Registrer	State of M	aryland / Dep <i>Ce</i>	artment o		nd Menta	Il Hygiene	M 12 000	26415
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	Funeral		5. Social Security Number		e (In yrs. last birthday)	If Under 1 Ye	ear If Under 2	4 Hrs. 8, Dat	e of Birth	9. Birt	holace (State or Foreign
	Director		216-08-8126	6. Sex 7. Ag	46 Yrs.	Months Da	ays Hours	Min. May	18, 1	959Gua°	temala
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d, Inside City Limits
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	ath with the Marylan s 23e or 28a-f show	Funeral Director	10e. Street and Number		1.010001	10f. Zip Coo	de		10g. Citi	izen of What Co	untry?
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	ems	iner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent If Yes, specify (of Hispanic Origi Cuban, Mexican,	in? (Specify Ye Puerto Rican,	s or No- etc.)	14. Race - Ame Black, White	
36	s afte	by Fu	1 Never Married XXMarr 3 Widowed 4 Divorced	ned 1 ☐ Yes 🔏 🛱 If Yes, Give Year or Dates:		XX Yes 2		Guatem			spanic
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Maryland 21215-0036	be fitted Hyad off	Be	17. Father's Name (First, Middle,						Middle, Maiden		
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ē	1 all Hea		20a. Method of Disposition		20b. Place of Disp		of 1	Date		ocation - City or	
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Baltimore,	permit, Pag Department Importent: I any injury o		21. Signature of Frineral Service	Licens	2	2. Name and A	ddress of Facility	Eckhai	rdt Fun	eral C	hapel P.A.
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of	Phys this al din	- T	1 Yes 2 No 27. Manner of Death	1 Linpati					Residence		cify)
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	A		30. Name and aderess of person	who completed cause of	death (Item 23a) (Type	Print)	ort la	OST MI	211	2/	
	Sta	ate	31. Date filed (Month, Day, Year	32. Regist	trar's Signature	14 011	007		211.	16	
	Regist		AUG 1 2 20	05 Receive	death (Item 23a) (Type 25 MA)	W					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 2:05 AM John Reckord 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death ospita 4b. City, Town, or Location of Death **Examiner** ROS edal B0-1 OUKI If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/15/1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ØM 2□F Days Min. 85 220-05-0452 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28e-f shov treumatic event, ITH Mcdical Examilter must be notified at 1 ☐ Yes 2 V No MD Completed by Funeral Director Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8738 Lackawanna Road United States 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:1941-1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Mever Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify White 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Tool and Die Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Heelth and Mental Raymond Cooper Reckord Helen Frankenfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 178 English Run Circle Sparks Glencoe, MD 21152 Betsy Bell /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once. Aug 1 ☐ Burial 2 1 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2005 ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CVA Enysician Cerebro Vascular acciden disease or condition resulting in death) UNKNOWN /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🛮 No 2 No 1 🗌 Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 9:00 f 52005 1 ☐ Yes 2 No Fell+/bm death. investigation Standing ros 2 Accident Director: 6 Could not be determined 28e. Plac of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rur Route Number, City or Town, State) 3738 - 0 (0 4 - Homicide within 24 hours after To the Funerel Dire 40 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

AUG 1 2 2005

C. JEFFLEY 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Print 12 Ffrey Land Man 9006 Franklin

square Prive Baltimol

		1 - For State Registrar		ryland / Depa	artment of I	Health and	Mental Hyg	leg. No.2 1 1 5	26417
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he Maryland 8a-f show	ector	Usual Residence of Decedent	e	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or items 23e or 28e-f show may injury or other traumatic event, the Medical Exactly or times be indifficed at once.	by Funeral Director	10e. Street and Number 826 Loyo1a Drive 11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No				Specify Yes or No- rto Rican, etc.)		encan Indian, ite, etc.
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E I and 2 sho Health and 1 tem 27 is ma		19a. Informant's Name/Relationship (Ty. Penelope ReVelle/W. 20a. Method of Disposition	ife	826 20b. Place of Dispo	Loyola Disition (Name of	rive Tow	on, MD 2	r, City or Town, State, 21204 20c. Location - City o	
Dealtimore, permit. Pages 1 ar Department of Hea Importent: If Item any injury or other	12	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Chesapea		tory Inc	Aug 11 2005	Beltsville,	Maryland
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To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Chack only 2 Medical Examinate and title of certifier 30. Name an address of person who	ner: On the basis of and manner stat	examination and/or in	29c. Licen	opinion, death occ	curred at the time, o	date and place, and du	e to the cause(s)
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			1 - For State Registrar	State of Marylan	•	nt of Health and I te of Death	Mental Hygler Reg. N	71115	26418
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	/Medic	al	Koland L	EE Kobi		Jr	August	8 200	
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	tar de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1Yes 22 No	J.S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (S becify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	
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altimore,	of Hi of Hi fiter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.	Removal from State	Place of Disposition (Necembery, crematory of	rother place)	Date 20c.	Both Me	
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Division of	To the Hospital or Attending Physicien: Tha I within 24 hours after death. To the Funaral Director: After this cartificata ha complataly filled in by tha funaral director, paga	Certification:	4 Homicide determined		iome, farm, street, lactory)	ory, office	28f. Location (Street City or Town, St.		Rural Route Number,
	To the Hospital or within 24 hours affa To the Funaral Dir complataly filled in	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause arred at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the complain	Me	29b. Signature and title of certifier		2	9c. License number	29d. [Date signed (Mon	th, Day, Year)
7) Horola (Cinsh	m	D36986	Au	gust 1	1,2005
			30. Name and address of person who Dehurah K. Au	nstrong 40		oadway P.	palt, more	mo	21231
	Sta		31. Date filed (Month, Day, Year) AUG 1 2 20	32 Registrar's Signa				, , , , ,	
	Registi	el 💮	I AUGIZZU	UJ PERBOAR A K	The Market of the second				

			State of Maryland / Department of Health and N 1- State Registrer Certificate of Death	Mental Hygier Reg. t	ZUUJ	26419
			1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physici /Medic		Betty Jane Rice		Day Year 2005	- CY PM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	,	4c. County of Death	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		Hart	ord
	Funeral Director		218-22-1169 1 D M 2 F 76 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 05/05/192	ar) 9. Birth Cou	place (State or Foreign intry)
			Usual Residence of Decedent	03/03/192	7 Macy	rana
	arylar show	_	10a. State 10b. County 10c. City, Town or Location		}	10d. Inside City Limits
	8e-f	ecto	MD Harford Havre de Grace			1 Yes 2 No
	ath with the Marylan s 23e or 28e-f show		100. Street and Number 10f. Zip Code		Citizen of What Cou	intry?
	leath	Funeral Director	100 Revolution St., Apt 307 21078 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	SA 14. Race - Ameri	ican Indian
ဖွ	ours after de al', or ftems Examiner m	Fun	Amed Forces? If Yes, specify Cuban, Mexican, Puerto 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Rican, etc.)	Black, White	, etc.
03	ours a	d by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:		Specify: Whi	te
215-0036	d within 72 ha piene. r than "natu ir e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	ring 16b.	. Kind of Business/Ir	ndustry
212	withir ene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+) 10th College (1-4or 5+) Homemaker		Home	
9	be filed tal Hygi d other event, I	Be Co	The managed by	e (First, Middle, Maid		
lan		To B	James Sidney Smith Flla Co	cilia Pric	ם ר	
		-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run			ip Code)
≥	and and mark		Kathy Morrison- Daughter in-law 704 Lewis Street, Havr			
Baltimore,	ges 1 t of H if ite		1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	Date 20c.	. Location - City or T	own, State
럝	t. Pag rtmen rtent: njury		`4 Donation 5 Dother (Specify) Angel Hill Cemetery 08/11	/2005 Hav		
Bal	permit. Pages 1 and 2 Department of Health s Importent: if item 27 is any injury or other tre		21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 123 S. Washington,	ral Home, Havre de G	P.A. Frace, MD	21078
			23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. UNG CANCED			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
		9.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
1	uted J ansit	Examiner	Cause (Disease or Injury that initiated events c. C. C. C. C. C. C. C. C. C. C. C. C. C.			
,	icate be executed physiclen and s the burial-transit	Exa	resulting in death) Last Due to (or as a construence of :			
68760,	icate be physicle the bur	dical	d			
		Med	IF FEMALE:			
Вох	leath certifii attending p I for use as	lan/i	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deliv	very Day Year
P.O.	the the	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			buy rou
٣.	res that the signed by be detact		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
) ecords,	quires n sign ald be	d by	Chronic obstaction Dumon may Distast	1 🗆 Yes	2 No 3 Pro	bably 4 Thinknown
	aw requas been 2 shoul	olete	Hypentonsion	24a. Was an	24b. Were aut	opsy findings available
Re	The lav	Completed	tipothy comism	autopsy performed1 1 ☐ Yes 2 ☐	l? 🔎 death?	ompletion of cause of
		BeC		h (Check only one)	10 103	2510
TY A	S S D	To E	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Other: 4 ☐ Nursing Ho	ome 5 Residence	6 ☐Other (Spec	ify)
	ing After une	lon;	27. Mann r of Death 1 Matural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe how in	njury occurred	
CR	deatl deatl ctor: / the	cat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury at home farm street feature of the could not be	28f. Location (Street	t and Number or Pu	ral Pouta Number
DIV	i or A after Direc	Certification:	4 Homicide determined determined determined determined determined determined building, etc. (Specify)	City or Town, St		ai Noute Number,
a	To the Hospitei or A within 24 hours after To the Funerei Direc completely filled in by	dical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cause red at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	ro the vithin ro the	Me	29b. Signature and title of certifier 29c. License number	29d. [Date signed (Month,	, Day, Year)
	. , - 0		Mi sup sim 046412		8/10/05	
	1		30. Larve and address of perion who completed cause of death (Item 23a) (Type, Print)	lane in		20
	2		21 Data filed (Month) (Day York) 29 Bellisted's Signature	MDE M	טוני לוו	7 r
	Sta Registr		31. Date filed (Month) Day, Year) AUG 1 2 2005 32. Registrar's Signature			

				ype or Print in BI State of Maryland						•	
			1 - State Registrar	otate of iviaryland		rtment of t		viciliai M	Reg. No	7 / m	261,20
			Negistrar Decedent's Name (First, Middle, Last)		007	inouto or	Dour	2. Date of D	eath		3. Time of Death
	Physici		ARKADIY		RE	SMAN		Month S	O		- 4:33 AM
	/Medic Examin		4a. Facility Name (If not institution, give s	reet and number)		4b. City, Town,	or Location of Death		40	. County of Dea	1 2 2
			SWAL HOSPITA	OF BALTINE	200	BALTIM	ORE CIT	4			N/A
ı.	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia:	st bilthday) Yrs.	If Under 1 Year Months Days		B. Date of B. (Month, D. NOV . 7	irth ay, Year	9. Bir	thplace (State or Foreigr
	Director		216-43-7767 X	77	115.			NOV. 7	, 15	321	"UKRAINE
	yland IOW		10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Limits
	med st	tor	MD BALTI	MORE			BALTIMO	RE			1 ☐ Yes 2 No
	of within 72 hours effer death with the Maryland plans.	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	•
	ath w		4 AMLEHT COURT #2				21215				USA
	er deg	Funeral		Was Decedent Ever in U.S. Armed Forces?	. 13. W	las Decedent of Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	14. Race - Ame Black, Whit	
36	rs afte	by F	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 🏹 No If Yes, Give Year or Dates:	1	□Yes 2X No	Specify:			Specify:	WHITE
Ş	2 hou		15. Decedent's Educ	ation		ent's Usual Occu			16b. F	Kind of Business	/Industry
21215-0036	nin 72 In 'na	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. D	aind of work done O NOT use retire	during most of wor ad)	king			
7	77 77 2	Completed			MECHA	NICAL E	NGINEER		SEA	PORT CO	NSTRUCTION
	be filed stal Hyg ad other event,	Be	17. Father's Name (First, Middle, Last)		55011		18. Mother's Nan	ne (First, Middl	e, Maide		5.0.TOFF! MAA
Maryland	2 should be and Mental is marked o	10	PETER		RESMA		ESFIR				PANTOFELMAN
<u>a</u>	s 1 and 2 should f Health and Mer Itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Typ	`			t and Number or Ru				
	f Health f Health itam 27 other tr		YELENA TEPER / WI 20a, Method of Disposition	FE 20b. Pla	WARAN .	ition (Name of	RT #2A -	DALITMU		MD 2121 ocation - City or	
jo J			1 X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	netery, crem	atory or other pla	CEM. 08/1			ISTERST	
altimore,	그 는 만 글		*4 □Donation 5 □ Other (Specify) 21. Signature Funeral Servic Leense	1		Name and Addr				& BROS.	
B	Depariment of the control of the con		Muchael 7	muger							MD 21208
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death.						JVILLES	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1							Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque	ence of):	3					
	Examiner		Sequentially list conditions, b	Chronic 1	uval	heral	ib's.				,
	p ii	lner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence oi):	,					
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90	w = .=	ш		240 (0 (0) 45 4 00) 35 44	31100 017.						
68760	phys phys s the	dic	d								
Box	the death certificate be y the attending physicie iched for use as the bur	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnan						23d. Date of de	livery
ĕ	death a atte	iclar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea		Ectopic pregnand Other (specify) _	Э			Month	Day Year
O.	by the a	hys	9 Unknown	9□ Unknown							
S,	The law requires that ite has been signed b bage 2 should be deta	by P	Part II. Other significant conditions con	1 1	_	derlying cause g	ven in Part I.	23e. Did			the cause of death?
ord	w require been si should I	ted	- Chrome ly rpt	rord devue	ru-a			1	Yes 2	1	robably 4 Unknown
ecc	e law r has be ge 2 sh	Completed						24a. Wa aut	opsy	prior to	utopsy findings available completion of cause of
<u> </u>	(0	Con						per 1 ☐ Yes	formed?	death? o 1 ☐ Yes	2 □170
Vital Records,	Physiclan: Th this certiticate al director, pag	Be	25. Was case referred to medical examiner?	ospital:		0	26. Place of Dea	ath (Check only	one)		
o	this al dii	10	1 Yes 2 Po	mpatient 2LE	R/Outpatient 28b. Time of	3 ☐ DOA 28c. Inju	4 Nursing H	lome 5 Res		6 ☐Other (Spe	ecify)
no	ding I h. After funer	flon	Natural 5 Pending	(Month, Day Year)	Injury	Wo	ork?]Yes 2□No	EGG. DOGGNE	7 110 W WIJ	ary occurred	
Division	Atten deat ctor: y the	flca	3 Suicide 6 Could not be	28e. Place of Injury - At hon	ne, farm, stre			28f. Location	(Street a	nd Number or R	ural Route Number,
á	ial or Attendir s after death. al Diractor: Al ad in by the fu	Certification:	4 Homicide	building, etc. (Specify)				City or T	own, Stai	te)	
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely tilled in by the fune.		29a. Certifier (Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examination	rledge, death	occurred at the t	ime, date and place	, and due to the	e cause(s) and manner a	s stated.
	in 24 tha Fi	Medical	one)	and manner stated.	on and/or my			irred at the time			
	To t To t	Σ	29b. Signature and title of certifier				se number	0:	29d. Da	ate signed (Mon	th. Day, Year)
,	4		Sniveral	1		PAS	NIO: 014	119.	X	1910	5
	N		30. Name and address of person who co	mpleted cause of death (Item :	23a) (Type, I	Print)			. Marine		
	St	ato	SRIVASAVI. C+	A GANULT 1 32. Registrar's Signatu	1 D	SIMAL	HOSPITA	TL 13 A	111	MOR (-	*
	Regist		AUG 1 2 20	- M	40 0	land .					

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JA Joedin ORIGINAL

			1 - For State Registrar	State of M	arylan	_	artment rtificate					Reg. No.	00	5 2	2642	21
ı	Physici		1. Decedent's Name (First, Middle, La: LaVerne Marie Rase								2. Date of Dea Month August	ath Day 10,	,	ž805	3. Time of 4:35	
	/Medio Examin	er	4a. Facility Name (If not institution, given Manor Care-Potoma)				4b. City, T Potor		Location of	f Death				of Death Omery	7	
	Funeral Director		5. Social Security Number 269-32-2735 Usual Residence of Decedent	ex 7. Ag ☐ M 2∏F	9e (In yrs. I 69	last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da March	h Year 2, 1	936	9. Birthpli Count Ohio	ace (State or	r Foreign
	Maryland a-f show illed at	tor	10a. State 10b. County Maryland Montgot	mery		y, Town or Lo	ocation							10)d. Inside Cit	·
	th with the 23a or 28a	Funeral Director	10e. Street and Number 10305 Glen Road				10f. Zip (208	Code 854						/hat Count	,	-
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event. The Medical Examinar must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	?		Was Decede If Yes, specification 1 ☐ Yes 2	fy Cubai	spanic Orig n, Mexican, Specify:	gin? (Spec , Puerto P	cify Yes or No Rican, etc.)		Black	America k, White, e	itc.	
Maryland 21215-0036	id within 72 h giene. ar than "natu i the Madical	Completed		(Specify only highest grade completed) (Sive kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Homemaker								16b. Kir	6b. Kind of Business/Industry Own Home			
yland	ould be file Menta! Hy arkad oth	To Be (17. Father's Name (First, Middle, Last, Leo W. Hall)							(First, Middle, nislo	Maiden :	Sumame	Θ)		
, Mar	and 2 she ealth and m 27 Is m		James J. Rascher			10305	G1en	Roa		toma	Route Number				Code)	
Baltimore,	Pages 1 ment of H tant; if Iter jury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)		, c	lace of Dispo emetery, crei e of Hea	natory`or ot! ven Cem	etery	7	ugust 20	13, 05	Sil	ver		ng, Mar	
Ball	permit Depart Import any in		21. Signature of Funeral Service Licer	25	_M01	433 Ro	ckvil	le,	Maryl	and	rt A. West M 20850-	2805	nrey	Fune y Ave	eral H enue	Iome/
	Pr ysicia n /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Metast	_{ine.} atic	Adenoc					r respiratory ar	rrest,			Approximate Interval Bety Onset and D Onths	ween
	Examiner	<u></u>	Sequentially list conditions.	b. Primar	y Bre	ast Ad	lenoca	rcir	noma					Ye	ears	
8760,	cate be executed oblysician and the burial-transit	cai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as												
O. Box 68	the death certific y the attending p ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	I death 3	⊒Ectopic pre ⊒ Other (spe					2	3d. Date Mon	e of deliver		ear ear
rds, P	sign sign d be	by	Part II. Other significant conditions of	contributing to death l	but not resi	ulting in the u	nderlying ca	use give	en in Part I.						e cause of de	
Vital Records,	The law ate has b page 2 s	Completed									24a. Was autor perfo 1 Yes	osy rmed?	p	rior to com leath?	sy findings a apletion of ca 2 \(\text{No} \)	available ause of
V.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpatier	nt 3[] DO/	A Othe			(Check only one 5 ☐ Resid		Othe	ar (Specify	3	-
sion of	ding After fune	ation: T	27. Manner of Death 1 Manual 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inj (Month, Da	ury	28b. Time o Injury		Bc. Injury Work		2	8d. Describe I					
Division	or or or or or or or or or or or or or o	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, e	tc. (Specify	y)					8f. Location (3 City or Tox	vn, State)				ber,
	To tha Hospital or At within 24 hours effer or To tha Funaral Direct completely filled in by	Medicai	(Check only 2 Medical Example one)	nysician: To the best miner: On the basis and manner s	of examina	wledge, deat tion and/or in	vestigation,	in my op	pinion, deat	d place, a th occurre	ed at the time,	date and	place, a	and due to	the cause(s))
	To with	×	29b. Signature and title of certifier	wol ne	0		D	313	number 19					1 (Month, E 11, 2		
	10		30. Name and address of person who Loreto Albiol, M.	completed cause of D. 8218 W	death (Item	n 23a) (Type, nsin A	Print) venue,	Su	ite 30	05, I	Bethesd	la, M	ary]	land	20814	
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 2 200	21	rar's Signa	iture Jose	is see									

hysici	×	1 - For Amend Item 18 Registrar 1. Decedent's Name (First, Middle, Las				2. Date of De			3. Time of Death
/Medic	al	Louis	Joseph	Ratajc	zak 3'rd	AUG.		2005	1826 P M
xamin	er	4a. Facility Name (If not institution, give 2421 EAST FAYETT	E STREET	BA	ty, Town, or Location of Dea LTIMORE CITY	ath	4c.	County of Dea	th
neral	1	Social Security Number 6. S	7. Age (In yrs	Month	der 1 Year If Under 24 Hr	n. (Month, Da	th y, Year)	9. Biri Co	thplace (State or Foreign
ector		218-21-6108 Usual Residence of Decedent	X 27	Yrs.		Aug. 16	197	7	Marylan
ust be retified at	7	10a. State 10b. County		ity, Town or Location					10d. Inside City Limits
288-1	Director	Maryland Baltimor 10e. Street and Number	e R	osedale	Zip Code		10a, Citiz	zen of What Co	1 Tyes 2 No
at he	al Di	7403 Barkdoll C	ourt Apt. D.		21237		_	U.S.A.	·
SC Je	Funeral	11. Marital Status	12. Was Decedent Ever in t Armed Forces?	J.S. 13. Was De- If Yes, s	cedent of Hispanic Origin? pecify Cuban, Mexican, Pue	Specify Yes or No arto Rican, etc.)	1	14. Race - Ame Black, Whit	
Examin	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		2 No Specify:			Specify: _	Vhite
Heal	Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's U	sual Occupation work done during most of w Tuse retired)	orkina	16b. Kir	nd of Business	/Industry
De Mari	mple	Elementary/Secondary (0-12)	Colfege (1-4or 5+)			y	Uar	ford Co	n at ation
*	e Co	17. Father's Name (First, Middle, Last)	NA	Trash C	ollector 18. Mother's N	ame (First, Middle,			natation
TIC OVER IT	To B	Louis Jos	eph Ratajc	zak Jr.	Karen			Eic	lman
		19a. Informant's Name/Relationship	Type, Print)		ess (Street and Number or I				
other traumatic		Karen Ratajczak J 20a. Method of Disposition		7403 Ba	rkdoll Court	Apt. D.	Rose	dale, N	Maryland 237
eny injury or other tra once.		1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	cemetery, crematory of		gust 12,	20c. Lo	cation - City or	Town, State
injur) e		4 □Donation 5 □ Other (Specify 21. Signature of Fungraf Service Licery		22. Name	and Address of Facility	2005			Maryland
eny in		1 julan ((Cherman	W. D	abrowski/Choj _Dundalk_Ave	jnacki Fu Baltimo	nera	1 Homes	s P.A.
		23a. Plant 1. Exter the disease, or com- shock, or heart failure. List only	olications that caused the dea	ath. Do not enter the m	node of dying, such as cardi	ac or respiratory a	rrest,	mar y rai	Approximate Interval Between
an		tmmediate Cause (Finat disease or condition			nd Cocaine Us				Onset and Death
cal ner		resulting in death)	Due to (or as a conse	quence of):					
	er	Sequentiafly list conditions, if any, leading to immediate	b Due to (or as a conse	quence of):					
	Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
		resulting in death) Last	Due to (or as a conse	quence of):					
,	dlcal		d						
	/Me	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					23d. Date of de	livery
	by Physician/Med	in the past 12 months?	1 Live birth 2 Fe		c pregnancy (specify)			Month	Day Year
	Phys	9 🗆 Unknown	9□ Unknown						
	by	Part If. Other significant conditions of	ontributing to death but not re	sulting in the underlyin	g cause given in Part I.				o the cause of death? robably 4 (Attinknown
	etec					24a. Was			
Da Da Da	Completed					autor perfo	psy ormed?	prior to death?	utopsy findings available completion of cause of
5	0	25. Was case referred to medical			26. Place of D	eath (Check only o	2 No	1 🗗 Yes	s 2 No
direct	To B	examiner? 1.☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	□ ER/Outpatient 3□	Othor	Home 5 Resid	-	S∭Other (Spe	ecity) AT SCENE
e funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury Fo(11111), Day Year) 8-8-05	Found P M	28c. Injury at Work? 1 ☐ Yes 2 No	28d. Describe I	how in jur	y occurred	unk
E fo	tifica	3 ☐ Suicide 6 M Could not b 4 ☐ Homicide determined		home, farm, street, fact	tory, office	28f. Location (Street and	d Number or 8	ural Route Number,
	Cer		Scene			Baltimo	re,	Md	
,	Medical	29a. Certifier (Check only one) 1 Certifying Ph Wadical Exam	ysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, death occurr nation and/or investigat	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	Me	29b. Signature and title of certifier			29c. License number			e signed (Mon	
	1	Aus -			O.C.M.E		AU	JG. 9,	2005
		LANCE Z							
completely filled in by the fu		30. Name and address of person who	111		EET, BALTIMORE	MADSZE AL	010	201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** SMITH LOKE 07:20 A M 08 12 200 /Medical 4a. Facility Name (If not institution, give street and number)
BALTIMORE REHABILITATION AND EXTENDED
CARE CENTER 4b. City, Town, or Location of Death 4c. County of Death Examiner 6. Sex 1 M 2 ☐ F Date of Birth (Month, Day, Year) 2 3 3 5, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 220-30-0798 Usual Residence of Decedent 69 Yrs Director with the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 Items 23a Van Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black 'natural', 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) orrectiona Father's Name (First, Middle, Last) Be and Mental F ٥ tilea 19b. Mailing A Jdrass (Street and Number at Swal Roug Number, City or it of Health Van yerre other 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Burial 2 Cremation — Donation 5 Other (Specify) ŏ 3 Removal from State permit. Page Department of Important: If any injury or ture of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stope disease or condition resulting in death) /Medical Due to (or as a cons- tience of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown ۵ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records. Mellitu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2] No Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 ENatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hour. the Funeral Direct 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. 29a. Certifier Medical (Check only one) To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 097804 on empleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 1900 Ballinove MD MROWIED Loch Raven Blvd.

Registrar

State

31. Date filed (Month, Day, Year)

AUG 1 2 2005

32 Registrar's Signature

			State of Maryla	and / Depa	artment of Health a	and Mental Hygi	ene				
			1 - State Registrar		rtificate of Death	Reg	2005	26424			
	Physicia	an	1. Decedent's Name (First, Middle, Last) OCETTA F. SHANK			2. Date of Death	Day Year	3. Time of Death			
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	HVSUST	10 2005 4c. County of Deat				
	LXamin	C1	616 Trimble Road		Joppa	•	Harford				
	Funeral		245 20 0400 1DM 20E	rs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	Min (Month Day	(ear) 9. Birti	hplace (State or Foreign untry)			
	Director		Usual Residence of Decedent	0 Yrs.		March19	,1935 Wes	stVirginia			
	anylan show	Ļ	10a. State 10b. County 10c. (City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
	the M.	Funeral Director	10e. Street and Number	Jopp	10f. Zip Code	10	Citizen of What Country?				
	h with	io is	616 Trimble Road		21085		USA	unity.			
	ema Sermu	Iner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican		14. Race - Ame Black, White				
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 ☑ No Specify:	Specify: Wh:					
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or itema 23a or 28a-f show event. Its Medical Exameration must be motified at	ted!	15. Decedent's Education	16a. Dece	dent's Usual Occupation	6b. Kind of Business/					
2	ithin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		dent's Usual Occupation kind of work done during mos DO NOT use retired)						
2	filed w Hygie Ither th	CO	5th 17. Father's Name (First, Middle, Last)	Hom	nemaker	own home					
Maryland	uld be dental rked o	To Be	Belba Sigmon			Tincher	,				
lary	2 short and N is ma		19a. Informant's Name/Relationship (Type, Print)	1	ng Address (Street and Number			(ip Code)			
	1 and Health em 27		Charles Shank / husband	. Place of Dispo	Trimble Ro		D 21085 Dc. Location - City or	Town, State			
ÕE.	Pages ent of nt: If It ry or c		1 PRurial 2 Compation 3 CRemoval from State	cemetery, crer	matory of other place) 11Cemetery		Baltimore				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event. The Medical Exumitive must be multilled at 90se.		21. Signature of Funeral Service Licens 22. Name and Address of Facility ConnellyFuneralHomeof								
	20529		K, Jerry Connell		300 Mace	Ave Balti	more MD	21221			
U			23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.		,	cardiac or respiratory arres		Approximate Interval Between Onset and Death			
	Pnysician /Medical		disease or condition resulting in death) Due to (or as a cons.		denocacinma	panci	inn and	V1001			
	Examiner	_	Sequentially list conditions, b.			pance	car)	093.			
Ţ	nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	equence of):							
ó	te be executed ysician and ie burial-transit	Exa	resulting in death) Last C. Due to (or as a const	equence of):			-				
8760,	a × a	dicai	d								
9 xc	eath certific attending pl	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of preg	jnancy			23d. Date of deli	verv			
. Box	death	Physician/Med	in the past 12 months? 1 Ves 2 Mo 4 Pregnant at time of		Ectopic pregnancy Other (specify)		Month	Day Year			
P. 0.	res that the de signed by the a be detached f	Phys	9 ☐ Unknown 9☐ Unknown Part II. Other significant conditions contributing to death but not re		ad a discourse of the Board	220 Did tobo	cco use contribute to	the serves of death?			
ds,	uires ti signe Id be c	d by	Taxin. Other significant containing continuing to dealir but not in	esulang in the u	indenying cause given in Fatt i.	256. Did toba	cco use contribute to				
COL	w requir been si should	te				1. Yes	2 ☐ No 3 ☐ Pr	obabiy 4 Unknown			
æ	\$ 00 CI	pic				24a. Was an	24b. Were au	obably 4 Unknown			
=	2 2 2	Comple				24a. Was an autopsy perform	24b. Were au	obably 4 Unknown topsy findings available completion of cause of			
Vita	ilcian: The law certificate has t rector, page 2 s	Be Completed	25. Was case referred to medical examiner?			24a. Was an autopsy perform 1 Yes 28 of Death (Check only one,	24b. Were au prior to death?	obably 4 Unknown topsy findings available completion of cause of			
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			State of Maryland / Departm	nent of Health and Me cate of Death	ntal Hygien	2005 26425				
	Physicia		1. Decedent's Name (First, Middle, Last) Anna Stoecker	2	Date of Death Month August	9 2005 3. Time of Death 6:30a M				
	/Medic Examin			City, Town, or Location of Death		c. County of Death				
				White MArsh		Baltimore				
	Funeral Director			nths Days Hours Min.	. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)				
			Usual Residence of Decedent		ct 21,1	915 Maryland				
	nyland		10a. State 10b. County 10c. City, Town or Location	n		10d. Inside City Limits				
	Ba-f s	octo		Marsh		1 ☐ Yes 2 X No				
	with ti	Funeral Director		of. Zip Code		Citizen of What Country?				
	ns 23	eral	5660 Gunpowder Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	21162 December of Hispanic Origin? (Speci		SA 14. Race - American Indian,				
ထ	after o	Fun	Armed Forces? If Yes, 1 □ Never Married 2 □ Married 1 □ Yes 2√€ No	Decedent of Hispanic Origin? (Speci , specify Cuban, Mexican, Puerto Ri	can, etc.)	Black, White, etc.				
21215-0036	ilied within 72 hours atter death with the Maryland Hygiene. ther than "natural", or Itams 23a or 28a-f show ant, Ira Madical Examiner must be naillisd al	d by	3⊠ Widowed 4 □ Divorced If Yes, Give 1 □ Y	es 2 No Specity:		Specify: White				
<u>5</u>	"natu	lete	(Specify only highest grade completed) (Give kind o	Usual Occupation of work done during most of working OT use retired)	done during most of working					
12	withiu iene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Marker		141.	Tailor Co.				
פ	e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (I	18. Mother's Name (First, Middle, Maiden Sumame)					
Maryland	should be and Mental a marked o	P	John Kral	France	s Sevic	•				
Mar	C1 00 - 100			dress (Street and Number or Rural F						
e)	1 and Health am 27		20a. Method of Disposition 20b. Place of Disposition	Gunpowder Road		arsh MD 21162 Location - City or Town, State				
OT.	Pages nent of I int: If its iry or o		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 3 ☐ Cremation 3 ☐ Cremoval from State 3 ☐ Cremation 5 ☐ Other (Specify)	Faith 8/12	4	ssville MD				
Baltimore,	# 원립를 .			ne and Address of Facility	- 11 - D	1 6.7				
m	Depa Impo any is		R. Lerry Connelly	300 Mace Ave	_	eralHomeofEssex				
п			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between				
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. End Stage Car	raestive he	artta	The 6 months				
	Examiner		Due to (or as a cons sulface of):	Loca diese	0.0					
Į.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Tery wist						
/	nd ransit	Examiner	that initiated events C.							
8760,	ate be executed hysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):							
687	ate he he	edical	d							
Box	death certifica attending ph d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ector	2070 57		23d. Date of delivery				
	the atte	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Othe	pic pregnancy er (specify)		Month Day Year				
<u>о</u>	t t		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underly	sing seuse given in Part I	33a Did tabassa	use contribute to the cause of death?				
ds,	signed be det	d by	Va S CHI A V A D M P A+11	ong cause given in Part I.		No 3 ☐ Probably 4 ☐ Unknown				
Record	w requir been si should	lete	The state of the s	-	24a. Was an	24b. Were autopsy findings available				
Be	The lav	Completed			autopsy performed?	prior to completion of cause of death?				
Vital		BeC	25. Was case referred to medical	26. Place of Death (1 ☐ Yes CON	10 TLY8S 2L NO				
) V	Physician: this certific al director,	10		☐ DOA Other: 4 ☐ Nursing Home	5 Residence	6 ☐Other (Specify)				
0	T = E		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at 28c	d. Describe how inj	ury occurred				
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ISIO	uttanding death. ctor: Afte y the fune	fication	2 Accident investigation M 3 Suicide 6 Could not be Great Place of	1 ☐ Yes 2 ☐ No	Location (Street	and Number or Bural Boute Number				
Division of	al or Attanding Ph : after death. I Diractor: After th d in by the funeral	ertification	2 Accident investigation M	1 ☐ Yes 2 ☐ No	f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)				
Division	ospital or Attanding hours after death. unaral Diractor: Afte ly filled in by the fune	cal Certification;	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, fabruilding, etc. (Specify)	1 Yes 2 No actory, office 28i	City or Town, Sta	to)				
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Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funarel Director: After this certification on pleasely filled in by the funeral director.	Medical Certification	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, far building, etc. (Specify) 29a. Certifier (Check only) Medical Examiner: On the basis of examination and/or investigation M 28e. Place of Injury - At home, farm, street, far building, etc. (Specify)	1 Yes 2 No actory, office 28i	City or Town, Sta	to)				
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Division	To the Hospital or Attending Within 24 hours after death. To the Funaral Director: After completely filled in by the fun	edical	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, far building, etc. (Specify) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur one) M 28e. Place of Injury - At home, farm, street, far building, etc. (Specify)	actory, office 281 urred at the time, date and place, and ation, in my opinion, death occurred 290 License number	d due to the cause(at the time, date at	s) and manner as stated. Individual place, and due to the cause(s) Individual place (Month, Day, Year)				
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			Amend item#	PIT, 25 perME, C87 State of Marylan	6,8/1	1705 TT	Health and I	Mental Hy	diene	
			For State Registrar	Otate of Marylan		rtificate o			Reg. N2 0 0 5	261,26
			Decedent's Name (First, Middle,	Last)	1,			2. Date of De	ath	3. Time of Death
	Physici /Medi		JUSEPH	SEABOR	N			Month 7	6 Day Year	7:47 PM
	Examir		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town	, or Location of Death	1	4c. County of Dea	th
			Bon Secours	Hospital		13A1+11			MA	
	Funeral Director		5. Social Security Number 6	Sex 7. Age (In yrs. 110 M 2□F	ast <i>birtnday)</i> Yrs.	If Under 1 Year Months Day		8. Date of Bird (Month, Da	th y, Year)	thplace (State or Foreign
			Usual Residence of Decedent					140016	0/(12/) 01	rginia
	arylar show	<u>_</u>	10a. State 10b. County		, Town or Lo					10d. Inside City Limits
	he Markers 1888-f	Director	MARYLAND NA	13A	Himo					1 Yes 2 No
	with t	급	10e. Street and Number	al stral		10f. Zip Code			10g. Citizen of What Co	ountry?
	death ms 23	Funerai	13 /6 Lex 11	12 Was Decedent Ever in II	S. 13.		223 f Hispanic Origin? (Sauban, Mexican, Puert	pecify Yes or No		erican Indian.
9	after or Ite	F	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give		If Yes, specify Cu		Rican, etc.)	Black, White	te, etc.
003	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		TILL YES ZUETN	lo Specify:		African	AMERICAN
21215-0036	filed within 72 hours after death with the Maryland Hygiene. thar than "naturel", or Items 23a or 28a-f show int, the Madical Examir at must be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	dent's Usual Occ	supation ne during most of work ired)	king	16b. Kind of Business	/Industry
12	filed withli Hygiene. thar than int, '''s M	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	Can	CPETE	Finishir	16	OWN Bess	ness
	e filed Il Hyg other	Be C	17. Father's Name (First, Middle, La	(51)	C011	Cecie		(First, Middle,	Maiden Sumame)	
/lar	2 should be and Mental Is marked o	ToE	Joseph Seal	DOCK			StiE	Sabo	ex	
Maryland			19a. Informant's Name/Relationship	(Type, Print)					er, City or Town, State,	Zip Code) 21233
	1 and 2 Health tam 27		SElma Births	20h B		w. Le	Lington Si		Altrancee N	
Baltimore,	permit. Pages 1 and Department of Health Importent: If Itam 27 any njury or other tr once.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	Removal from State	emetery, cre	matory or other p	lace) July 1.	Date 2, 2005	20c. Location - City or	
薑	permit. Pag Department Important: Imp njury c		*4 ☐ Donation 5 ☐ Other (Special Service Line)		+ , 21	Name and Add	tress of Facility • /o.	kind on did	Ansdowne,	MARYLAND
B	Department Impo		Maudet 1	. Tuesase	1 31	105 W. FR	eauxlin Sti	ee+-134	Himore MI	MARYIAND RAI SCRUICE ARYIAND 1229
	_		23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the death	n. Do not en	ter the mode of d	ying, such as cardiac	or respiratory as	rrest,	Approximate Interval Between
₽	Pnysician,		Immediate Cause Final disease or condition	ny one cause on each mie.			1 +1	. /	/ /	Onset and Death
	/Medical Examiner		resulting in death)	Due to for an a consequ	uen: of):	nye	pun	101		Word C
	Lxammer	يد.	Sequentially list conditions,	b. 10100	terre	Chin	/ /	////	2	days.
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for is Promsequ	ience of):	h /	//			-
ς,	le be executed ysicien and e burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as a consequence	ience one	174	CLUNGE	CAL	DICAL EXAMINENT	tion the
760,	ysicie	cai		d		<i></i>	CERTIFICATION	APPROVED BY ME		
68	res that the death certificate be executed igned by the attending physicien and be detached for use as the buriat-transit	Medi	IF FEMALE:				CERTIFICATION			
Š	Attending Physician: The law requires that the death certifica rideath. actor: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3[∃Ectopic pregnar	псу		23d. Date of de	,
70	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (specify)			MOTH	Day Year
<u>:و</u>	that the ed by detac	/ Ph	Part II. Other significant condition	s contributing to death but not rest	ulting in the u	inderlying cause of	given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
// Records	luires r sign	d by	COPD Hum	Incian 1)	pless	Ca PIII			robably 4 Unknown
$-\sqrt{2}$	s beer	iete		acc A co	. '4	P	1	24a. Was	an 24b. Were au	utopsy findings available
Re-	The ta	Completed	acing in	ass, mein	-56/				prior to death?	completion of cause of
Vital	slcian: The certificate I rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea			2 3 140
٥	hysic this ce al dire	0	1X Yes 2∏√√		EF/Outpatier	IL 3LI DOA		ome 5 🗆 Resid	dence 6 □Other (Spe	ecity)
7 5	ding F	lon	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W	lork?	28d. Describe h	now injury occurred	
Division	Attendideath.	ficat	2 Accident investiga 3 Suicide 6 Could no	t be	me farm st		□Yes 2□No	28f Location /5	Street and Number or Ri	ural Route Number
ζĠ	after after I Dira	Certification: T	4 Homicide determin	building, etc. (Specify	")	oot, tablery, onle		City or Tox	vn, State)	ara mosto mambor,
L.	To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funaral Director: After this certificate has been si completely filled in by the funeral director, page 2 should		29a. Certifier Certifying (Check only 2 Medical Ex	Physician: To the best of my known	wledge, deat	h occurred at the	time, date and place,	and due to the	cause(s) and manner as	s stated.
	the H nin 24 the F nplete	Medical		taminer: On the basis of examinat and manner stated.	and/or in					
	Twith To	2	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (Mont	h, Day, Year)
1	11)			eg MD.		5	1/202	_	11716	55
(7		30. Name and address of person wi	no completed cause of death (Item	23a) (Type,		1.15	BALT	*******	Nan ninta
1	Sta	ite	31. Date filed (Month, Day, Year)	32. Pogistrar's Signa	ture	ENA	AVE	12 HL	MOKE	Mp21222
	Regist		AUG 1 2	2005 See 2	5 A	on the				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:10P Yea **Physician** rone 05 RONICO /Medical 4a. Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ichriot BALTIMORE 10WSON If Under 1 Year | If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 232-26 1 □ M 2 1 E Months Days Hours Yrs. Director Virginia Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at Completed by Funeral Director Baltimores 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2123 USA 1820 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be tiled with dealth and Mental Hygiene. 12 uste 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Be ationship ype, Print) 19b. Mailing Address (Street and Number or Rural , ute Number, City or Town, State, Zip Ode) itam 27 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location permit. Pages 'Department of H Importent: If its any injury or ot once. Burial 2 Cremation 3 Removal from State Burial 2 Other (Specify) 15.05 PARKVIlle MI BALTIMORE, MO 21234 emetera 21. Signature of Funeral Service Licen acility VANS FUNCHAPER 8800 HARDORD RD. 23a. Part1. Enter the disease, or shock, or heart failure. Lis ath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 ☐ Yes 2 🕅 No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes or Attending Physician: 25. Was case reterred to medical examiner?
1 □ Yes 2 ⋈ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Division of After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death, To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident tilled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25205 who completed cause of death (I -m 23a) (Type, Print) harles St. Balto Mit

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

			For State Registrar	State of	Marylar		artment o			and Me		0	005	201.00	
			Registrar 1. Decedent's Name (First, Middle, L.)	ast)		- 00	Timeate	01 0	Calli	2.	Date of Dea	Reg. Nø.	000	3. Time of Death	
	Physicia		Frances	Charlott	:e	Stief	e1				Month August	Day	2005	4:15 P M	
	/Medic Examin		4a. Facility Name (If not institution, g		ber)		4b. City, Tov	wn, or L	ocation o	of Death			County of Death		
			4701 Willard Av						Chase			1	Montgome	ry	
	Funeral Director		5. Social Security Number 6. 046-18-9908	Sex 7	. Age (In yrs. 82	last birthday Yrs.		ear ays	If Under 2 Hours	Min.	Date of Birth (Month, Day)ct. 20	0,192	Cour	elace (State or Foreign etry) York	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or	_ocation						1	0d. Inside City Limits	
	Maryll f sho	tor	Maryland Montgo	mery			C	hev	y Cha	ase				1 Xves 2 No	
	r 28a	Director	10e. Street and Number				10f. Zip Co	de				10g. Citiz	en of What Cour	ntry?	
	th with	alD	4701 Willard A	ve. #721				208	815			Uni	ited Sta	tes	
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event. The Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	ces? 2 X INo	J.S. 13	. Was Decedent If Yes, specify	Cuban	panic Orio , Mexican Specify:	gin? (Specif i, Puerto Ric	Rican, etc.) Black, White, etc.				
21215-003	72 ho natur ilcali	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) S+ Teacher							of working	dustry					
2	within 72 telene. than "nateles	mple	Elementary/Secondary (0-12)	College (1-	4or 5+)	life	DO NOT use r	etired)		,	of working				
2	iled w Hygier ther ti	S	17. Father's Name (First, Middle, La	5 +		1	Teach		18 Mothe	r's Name /F	irst Middle		Educatio	n	
ano	d be i	To Be	Jacob P	•	riedma	an				Sadie	's Name <i>(First, Middle, Maiden Sumame)</i> adie Ruth Spielm				
Maryland	shoul	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Ma	ling Address (Si	treet ar	nd Numbe	or Aural A	Route Numbe	r, City or	Town, State, Zip		
	and 2 alth a 27 is		Douglas P. Stie	fel / Son	l	310	6 Jenni	ngs	Rd.,	, Kens	ington	n, MI	20895		
altimore,	of He of Herr		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	□Removal from S		Place of Dis	oosition (Name of ematory or other	of r place,)	Date	9	20c. Loc	cation - City or To	own, State	
Ĕ	Pages Iment of I tant: if it		`4 □Donation 5 □Other (Spec				MemorGa:			8/12/			Lney, MD		
Bai	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service The	gisee muu	M003	32	22. Name and A Rapp Fui 933 Gisi	nera	al &	Crema Silve	tion S	Servi	ices MD 20	910	
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	Pnysician		Immediate Cause (Final disease or condition	-		y Sud	den Deat	:h						Onset and Death	
	/Medical Examiner		resulting in death)		rasa consec		n.								
l.	LAMITHE	_	Sequentially list conditions.	b	oronar		ery Dise	ease	3						
1	ted nsit	nlne	if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury	D00 10 (C	as a consec	querice or).									
o î	ficate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (c	r as a consec	quence of):									
8760,	ate be nysicie he bur	dlcal		d											
9	artifica ing ph e as t		IF FEMALE:												
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	res that igned b	by Pt	Part II. Other significant conditions	contributing to dea	ath but not res	sulting in the	underlying caus	e giver	n in Part I.		23e. Did to	bacco us	se contribute to the	ne cause of death?	
g	w require been sig should b										1 □ Y	′es 2.2	Ño 3□Prob	ably 4 Unknown	
Il Records,	The law re ate has bee page 2 sho	Completed												psy findings available impletion of cause of	
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:							Check only o				
ot	Phys this ral di	: To	1√√es 2 No 27. Manner of Death	1 □ In		ER/Outpati 28b. Time		Other Injury	4 🗆 140	-	5 X Resid		Other (Specify	y)	
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Division of Vital	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Certification	3 Suicide 6 Could not determine	200. Place	of Injury - At h g, etc. (Speci	nome, farm, :	street, factory, of	ffice		28f	Location (S City or Tow	Street and m, State)	i Number or Rura	l Route Number,	
	spital ours a neral filled		29a. Certifier XXCertifying	Physician: To the I	pest of my kn	owledge, de	ath occurred at t	he time	a, date an	d place, and	d due to the	cause(s)	and manner as s	lated.	
	To the Hospital or A within 24 hours after To the Funeral Direction properties of the Funeral Direction by the Funeral Di	edical	(Check only 2 Medical Ex	aminer: On the ba and mann	sis of examina	ation and/or	investigation, in	my opi	nion, deal	th occurred	at the time, o	date and	place, and due to	the cause(s)	
	To t Com	Σ	29b. Signature and title of certifier	land			29c. L		number 1 3927	7		-	e signed (Month,	Day, Year)	
	1		//					TID.	1321			0.(0.05		
	15		30. Name and address of person what Augusto Pichard	, M.D.; 1	10 Irv	ing S		Wasl	hingt	on D.	C. 20	0016			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 2 20	30. Re	aistrar's Sian	ature								-	
		7	Und T C Co	VY JUNE	No.	1									

nucicia		1. Decedent's Name (First, Middle,	Lact		Ce	rtificate of	Death		2. Date of Dea	Reg. No.	105	2642
hysicia		Frank Simmons	, Lasi/						Month	Day	Yeer	3. Time of Dec
Medica xamine		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of		ugust		2005 unty of Deat	2
X.C.IIIII		Union Memorial	Hospital			1	Baltin	nore			,	
neral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. la		If Under 1 Year Months Days	If Under 2	24 Hrs.	8. Date of Birt (Month, Day	h v. Year)	9. Birtl	hplace (State or Fo
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ž 11		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	ocation						10d. Inside City L
Dail 1	to	MD Baltin	nore	Park	kvil1e	•						19 Yes 2
and a	Director	10e. Street and Number				10f. Zip Code				10g. Citizer	of What Co	untry?
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reumatic event	To Be	17. Father's Name (First, Middle, L Richard T. Simmo	,						(First, Middle, Wagner	Maiden Sui	тате)	
other treumatic		19a. Informant's Name/Relationshi	6 1 36		19b. Mailie	ng Address (Street	and Number	r or Rural	Route Numbe	r, City or To	own, State, Z	(ip Code)
r other tre		Charlotte Simmons	s/Wife			Chesley		e Par	kville	, MD	21234	
		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.		·		esition (Name of matory or other place ke Cremat	1		ug 11		ion-City or i	Town, State Maryland
any injury or once.		21. Signature of Funeral Service L	icensee R ++ - N	101111	22 C	2. Name and Address remation a 717 Green	ss of Facility	neral	Alterna	atives		99 2 95 95 95
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uiner parial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate as a list of the sequence of the se	b. Due to (or as	s a conseque	ence of):		3					
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en bracker. After this certificate has been agreed by the attending proyectan and led in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigated and the inve	b. Due to (or as d. 23c. If yes, outcome d. 23c. If ye	e of pregnan 2 Fetal c t time of dea but not result iury - At hom tc. (Specify) of my know of examinatic tated.	ence of): ence of): ence of): ency death 3 [ath 5 [thing in the unit of the content of the	Other (specify) Indertying cause given the state of the specific cause given the state of the specific cause given the state of the specific cause of the specific cause of the state of the specific cause of the specific	26. Place er: 4 Nur. y at k? Yes 2 N me, date and pinion, death	28 No 28 d place, an	24a. Was a autop perfor 1 Ves (Check only or e 5 Resid ad. Describe had a the time, c	des 2 No an 2 an 2 an 2 an 2 an 2 an 3 an 3 an 4 an 3 an 4 an 5 an 6 an 6 an 6 an 7 an 7 an 7 an 8 an 8 an 8 an 8 an 9 an	Month contribute to do 3 \sum Pro 4b. Were authorior to ordeath? 1 \sum Yes Other (Special Courred) distribute to distribut	the cause of death obably 4 Qunkr topsy findings avaiompletion of cause 2 No
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			Registrar	/First Middle La	etl		Ce	runca	e oi	Dealli	2. Date of De	Reg. No.		3. Time of Death	
	Physici		1. Decedent's Name (First, Middle, Last) Gerald Thurman Scheffey					Month				Day		1:05 P M	
	/Medic				re street and number)			4b. City	Town, o	or Location of Dea	AUGUS		2005 County of Death		
	Funeral Director	ler	VA MARYLAND HEALTH CARE SYSTEM 5. Social Security Number 181-22-7585 1 Age (In yrs. last birthday) 1 Age (In yrs. last birthday) 1 Yrs. 75 75 75 75 75 75 75 75 75 7							rth	CECIL 9. Birthplace (State or Foreign Country) Pennsylvania				
9			Usual Residence of Decedent									. , , ,			
arvlar	show	_	10a. State		10c. City, Town or Location								10d. Inside City Limits 1 Yes 2 No		
M ec	"natural", or Items 23a or 28a-f show edical Exercinet must be redified at	Director	MD	Harfor	.d	Aberdeen									
with t			10e. Street and Number				10f. Zip Code						zen of What Cou	intry?	
eath		erai	503 South Law Street 11. Marital Status 12. Was Decedent Ex				21001 ver in U.S. 13. Was Decedent of Hispanic Origin? (\$					Specify Yes or No- 14. Race - America			
safter d		y Funerai	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2			No 1 Ves of Vale			an, Mexican, Puèi Specify:	n, Mexican, Puerto Rican, etc.)			, etc.		
13-0030 in 72 hours after death with the Maryland	"natural",	d by	3 Widowed 4 Divorced Year or Dates:				1948-52					105 10	Spacify: White		
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and,	Mental Hygiene. arked other than atic event, the M	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	dle, Maiden Sumame)			
arylal should b		Tof	Charles S	scheffey						Elsie	Shaner				
lar 2 sho	and M is mar		19a. Informant's Na		**			3		and Number or R			,	p Code)	
6, 5	tment of Health rant: If item 27 ijury or other tr		Deidre Ch		ghter					ourt, Lo	uisville Date	-		Town State	
			20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Grv. UMC Cem. 08/09/2005 Pleasant Grv. UMC Cem. 08/09/2005									Oc. Location - City or Town, State			
Saltimor				5 Other (Speci		Pre				T-00-0					
ם פ	Depa Impo any ir		21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078												
		iner	23a Part Foter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate												
2	nysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death												
	/Medical		disease or condition resulting in death) a. CARCINOMA OF ESOPHAGUS AND STOMACH WITH UNKNOWN Due to (or as a consequence of):												
E	raminer -transit		Conventially list our		LIVER METASTISIS										
70			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):												
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Cords, F.O	been signed by the should be detached	by									2 No 3 Probably 4 Thinknown				
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	this certific	Bec	25. Was case refer	red to medical						26. Place of De	eath (Check only				
07		Tof	examiner?	No	Hospital: 1 Inpatie	int 2	ER/Outpatie	nt 3□D	OA Ot	her: 4 Nursing	Home 5 ☐ Res	idence	6 □Other (Spec	ify)	
io u			27. Manner of Death	28a. Date of Inju (Month, Da	of Injury h, Day Year) 28b. Time of Injury			28c. Inju Wo		28d. Describe how injury occurred					
SIO Tend	death. tor: After the funer	cati	1 Selatural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 4 Homicide determined (Month, Day Year) Injury Work? M 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street a City or Town, Sta							296 Leasting					
DIVISION Lor Attending	after d Direct I in by	Certification;									and Number or Rural Route Number, ate)				
Hospita	within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ledicai C											stated. to the cause(s)		
o the	vithin To the	Me								29d. Dat	I. Date signed (Month, Day, Year)				
-	> - 0		I Marke Flower I						D20390 A				UGUST 5, 2005		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							2005							
	CHARLES HOESCH, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 2								T,MD 2190						
	Sta Registr		31. Date filed (Mont	th, Day, Year)	32. Registr	_	ture								

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1 - State Registrar C						Certifi	icate of l	Death	Reg. No	0.05	25431		
İ	Physici /Medic	_	1. Decedent's Name (First, Middle, Last) Sarah Lee Sedler			2. Date of De. Month	Day	7, 2005	3. Time of Death 5 20 44 M				
	Examin		4a. Facility Name (If not institution, give s	46	4b. City, Town, or Location of Death				4c. County of Death NA				
	Funeral Director		5. Social Security Number 6. Sex 218-24-7798		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Aug. 9,	v. Year)	C	nthplace (State or Foreign ountry) ryland			
aryland 21215-0036	aryland show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L				timore			10d. Inside City Limits 1⊠Yes 2□No			
	or 28a-f	Director	Md. n/a		Of, Zip Code	21206	10g. Citiz	zen of What C					
	• 23•		6106 Everall Avenu	112 14/20				14. Race - American Indian,					
	tal Hygiene. do that then "natural", or lieme 23e or 28e-1 ehow event, the Medical Exercitors must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes, 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of If Yes, specify Cub If Yes, Give 1 □ Yes 2 □ No				of Hispanic Origin? (Specify Yes or No- cuban, Mexican, Puerto Rican, etc.) No Specify:			Black, Wh		
	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		1	(Give kind	's Usual Occupa of work done of	luring most of wor	rking	16b. Kir	nd of Business	s/Industry	
	Mithin In In In In In In In In In In In In In	ldu	Elementary/Secondary (0-12)	College (1-4or 5		homemal	NOT use retired)			own ho	mo	
2	filed with Hygiene other the		10 years no (First, Middle, Last)				ker	18. Mother's Nan	ne (First, Middle,	Maiden			
lan	should be filed with nd Mental Hygiene marked othar the imatic event, the	To Be	Charles Six										
e, M	nd 2		19a. Informant's Name/Relationship (Type, Print) Michael O'Brien 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z. 13604 Bedford Road, N.E., Cumberland,								Zip Code) Md. 21502		
	Pages 1 and nent of Healt int: If Item 2 iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 0ak Lawn Cemetery 8/11/2005 Baltimore										
Baltii	permit. Pages Department of Important: If it any injury or one		21. Signature of Funeral Service License	-000-	1	S		k Funera					
			23a. Part1. Enter the disease, or complishock, or heart faiture. List only or	cations that caused	the death. I	Do not enter th	10 W. M ne mode of dyin	acPhail g, such as cardiad	Road - Be or respiratory a	rrest,	r, Md.	21014 Approximate Interval Between	
F	Physician /Medical Examiner		Immediate Cause (Final disease or condition Myocar DIAC INTAGCT or								Onset and Death		
*(resulting in death)	MYGCAPOIAU INTARCTION Due to (or as a consequence of): NINTS EXES MELLITUS T									
	* *	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):									
	cuted	Examin	Cause (Disease or injury that initiated events										
, 60, 60,	be executed sicien and burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):										
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O. Box 6	ne death certificate the attending physiched thed for use as the t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery Month Day Year			
<u> </u>	res that the de igned by the a be detached t	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								co use contribute to the cause of death?		
rds	w requires been sign should be		HYPER LIPIOEMIA 1-Yes							Yes 2	2 No 3 Probably 4 □Unknown		
Division of Vital Records, P.O	Physician: The law re this certificate has ber al director, page 2 sho	Completed	HYPERTENJION 24a. Was an autopsy performe 1 yes 20							psy			
	cian: artifica ictor, p	Be C	25. Was case referred to medical examiner?										
	Physic this ce al dire	မ	1 □ Yes 2 No					4 Nursing r	Home 5 Residence 6 Other (Specify)				
	nding F ath. r: After e funer	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work?					28d. Describe how injury occurred				
Divis	tal or Attending Pri	Certification:	3 Suicide 6 Could not be 4 Homicide determined	e, farm, street,	eet, factory, office 28f. Location (St. City or Town				reet and Number or Rural Route Number, n. State)				
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best oner: On the basis of and manner sta	examination	edge, death oc n and/or invest	curred at the tin igation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner a place, and du	as stated. e to the cause(s)	
	within To th compl	Me	29h Signature and titles certifier 29d. Date signed										
			1/1100		N-1 DE3867					08-09-2005			
	il		30 Name and address of person who co	0000		3a) (Type, Prin	nt)	n Rela	un n	05	31150	M 212	
	Sta	10	CESARG G 31. Date filed (Month, Day, Year)		ar's Signatur	e W	294	0 1726	not fly	017	usus/	1011 1111	
	Regist			005	40 . 4	4. Lu	and a						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Seibert George Charles Month Dav **Physician** August 8, 2005 4:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mt. Carroll Sun Valley Assisted Living Ctr. Airy If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months **™** 2□ F Director 218-28-6789 March 22,1932 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location ir then "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 10d. Inside City Limits Westminster 1 ☐ Yes 2X No Carroll Co. Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 United States 200 Mozart Drive death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Accounting Supervisor 12 should be filed w h and Mental Hygier 7 ie marked other ti Steel Industry 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George J. Seibert Catherine Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Heelth ar Important: If item 27 ie eny injury or other treu once. Carolyn S. Henning (Sister) 5376 Glenthorne Ct. Baltimore, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 ☐ Donation

5 ☐ Other (Specify) 8/10/2005 Baltimore, Maryland 21. Signatur v f uneral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart allers. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardia MAD /Medical Due to (or as a consequence of): Examiner Cardine Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit law requires thet the death certificate be executed Comman Due to (or as a consequence): Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the deteched 9 Unknown 2 signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 3 Probably 4 dunknown as been si 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificete l 20 Vital loved 2 🖸 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funerel director, Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 5 this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Aftert Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 1 atural 2 Accident 5 Pending within 24 hours efter death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the s 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Wester 32 Registrar's Signature State AUG 1 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:55 AM DILDUR 06,200 /Medical Johns Hepkins Bayven Medical

5. Social Security Number 6. Sax 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Baltimore (enter N/A 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 15€M 2□F 219-32-3361 69 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner toust be notified at 1 Yes 2 No Director Baltimore Maryland Colgate 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7065 East Baltimore Street Itema 23a 21224 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter bent of Health and Mental Hygiene. The filem 27 is marked other than "natural", or lite any or other traumatic event, Ita Macket Examins 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry na most of working Elementary/Secondary (0-12) College (1-4or 5+) Utilities Gas Main Repairman 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lillian M. Carey 2 Wylbur R. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21224 7065 East Baltimore Str. Mrs. Rose Marie Smith (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns. 8/9/2005 Timonium, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) repsis **Physician** /Medical Due to (or as a consequence of): **Examiner** neutropenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ano truap burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician cances the for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by page 2 should be 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 > Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA his 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 Yes 2 No death. 2 Accident investigation thours after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 Den Senting DEM SONGUESTA, MD RES-000 August 06, 2005 Johns Hopkins Bayview Med. Ctr. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 4940 Eastern Ave. Devi Singupta, M.D. 31. Date filed (Month, Day, Year) State Registrar 2005

DHMH 17 Rev 1/2001

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Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 **Physician** AUGUST 9, **SCHWARTZ** 11:11 A M DEBRA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **BALTIMORE** HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year) AUG. 7, 1953 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1□M 2 F 52 Yrs. NY 215-56-4102 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d, Inside City Limits r than "natural", or Itama 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ▼ No BALTIMORE OWINGS MILLS Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 USA 2 BELLADONNA COURT Funerai 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Compi College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. **MERCHANDISER** REVLON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if item 27 is marked oth any lijury or other traumatic event ang lijury or other traumatic event ange. Be BERNARD WEINER ESTELLE STEINBERG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 BELLADONNA COURT - OWINGS MILLS, MD 21117 LAWRENCE SCHWARTZ / HUSBAND 20a. Method of Disposition
1 IXBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State HEBREW YOUNG MEN CEM | 08/11/2005 WOODLAWN, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Ger ice Lice see 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 rant . Either the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. Ut with one cause on each line. Approximate Interval Between Onset and Death Imm adate Cause (Final months Physician metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 □Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) O 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier und Mon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Balto Md 6701 BINC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

SchulfRTZ, Debra

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Maryland		artment of F			giene Reg. 2.005	26436
Dhusis		Decedent's Name (First, Middle, Las	()				2. Date of De	ath Day Yea	3. Time of Death
Physic /Med		Howard L. Schurn					July 3	30, 2005	5:08 PM M
Exam	iner	4a. Facility Name (If not institution, give Upper Chesapeake	, and the second	r	4b. City, Town, o Bel A		f Death	4c. County of De	ford
Funera	1	5. Social Security Number 6. Se	7. Age (In yrs. las		If Under 1 Year	If Under			irthplace (State or Foreign
Directo		212-28-1062	ZM 2□F 75	Yrs.	Months Days	Hours	Min. (Month, Da May 31,	1930 Ma	ryland
/land		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
Mar.	ctor	MD Harford	1 1	Bel A	ir				1 Yes 2 No
vith th	Director	10e. Street and Number			10f. Zip Code	010	1.1	10g. Citizen of What	Country?
eath v	era	410 E. MacPhai	L KOAd 12, Was Decedent Ever in U.S.	13 \	Was Decedent of H	210		USA	nerican Indian,
I e., INICILIY STATION AT INICILIAN STATES THE GOOD WITH THE MARYLAND STATES THE ADMINISTRATION OF THE MARYLAND STATES AND AT INICILIAN STATES AND AT INICILIAN STATES AND AT INICILIAN AT INICIPIAN ATI	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		fYes, specify Cuba 1 ☐ Yes 2🂢 No	Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)	Black, Wi	
72 hou		15. Decedent's Ed (Specify only highest gra		16a. Deced	lent's Usual Occup	ation	t of warking	16b. Kind of Busines	ss/Industry
Aithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	d)	or norking		
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is 1 and 2 should be filed within is 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other then other treumatic event, ITEM	To Be	Tr. Father S Hame (r not, imode), East)			unk		in a reality (r many		ulik
2 should I		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street	and Numbe	or Rural Route Numb	er, City or Town, State	, Zip Code)
C, IV		Suzette Mignini/s			113 Abin	gdon,	MD 21009	20c. Location - City	or Town State
Pages nent of h		1 Burial 2 Cremation 3 D	Removal from State		natory or other place	ce)		Loo. Country	51 15411, 514.6
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tre		*4 □ Donation 5 ☑ Other (Specify 21. Signature of Suneral Service Licen Ronal Ld S		St	. Name and Addre	ss of Facilit Omy Bo	Sard 655 W.	Baltimore	Street
	i .	meny	1 well	Ва	ltimore,	MD 2	21201		
Physician		23a. Park. Enter the disease, or come shock or heart failure. List only disease or condition resulting in death)	one cause on each line.		erbati		cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
/Medica Examine		resulting in dealth)	Due to (or as a conseque				1		10 days
	ē	Sequentially list conditions, if any, leading to immediate	Due to (o s a consequen	nce of):	D055.	Thou	ignant		10 days
cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c		171				
b be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequent	nce of):					
physicate by the k	dical		d						
certification of the angle of t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance		75			23d. Date of c	delivery
Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 2 □ Fetal de 4 □ Pregnant at time of dea 9 □ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
that the by	by Ph	Part II. Other significant conditions of	ontributing to death but not resulti	ing in the u	nderlying cause giv	en in Part 1.	23e. Did t	obacco use contribute	to the cause of death?
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taw requast been 2 should	Completed						24a. Was	osy prior t	autopsy findings available o completion of cause of
The cate h	Con						perfo	rmed death 2 No 1 Y	
vicion: 'siclon: 'certifica	o Be	25. Was case referred to medical examiner?	Hospital:		oth	05	of Death (Check only of		
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ending sath. or: Afte	catio	1 Natural 5 Pending 2 Accident investigation		пцагу		Yes 2 □ I	No		
or Att after de Direct	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (- City or Tor	Street and Number or vn, State)	Rural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Ph	ysicien: To the best of my knowle niner: On the basis of examinatio and manner stated.	edge, deatl n and/or in	n occurred at the tirvestigation, in my o	me, date an pinion, dea	d place, and due to the the cocurred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To th within To the	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
		2 June 1			り.	565	45	8/1/03	5
		30. Name and address of person who	completed cause of death (Item 2	(Type,	Print)		45 02, Bel A	1'. M.D	2.2.1
³² C	tate	Shilpi Khosia. 31. Date filed (Month, Day, Year)	1. U. 206 H	rays	ST. 31	c. 1	02, 561 K	עוין, ויוע	21014
Regis		AUG 1 2 200		bra	de D				

DHMH 17 Rev 1/2001

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1/30/05

Schurman, Howard

ORIGINAL

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Thompson 3:00 PM Mabel TULY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL NA GOOD SAMARITAN BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10-29-22 5 Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 1 F Months Days 224-26-7391 Director Va. Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 28a-f show treumatic event, the Medical Examiner must be notified at Yes 2 No Md. NA Baltimore Director the ! 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1905 Cecil Avenue 21218 USA Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No ŏ Specify: Black Specify: 3 Widowed 4 □ Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hyglene." n 7 is marked other then "n. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Other People Homes 5th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Street Myrtle Braxton Clayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Thomas Cousin 1905 Cecil Ave., Baltimore, Md. 21218 item 27 other 20a. Method of Disposition
1 △Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Department of Importent: If it eny injury or o Md. Vet. Cem 7-28-05 Crownsville, Md. ' 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21202 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** WOUND INFECTED (decubitus ulcer) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner GERTIFICATION APPREVED BY MEDICAL EXAMINER burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by MELLITUS DIABETES 1 Yes 2 No 3 Probably 4 Onknown CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes VINO 24a. Was an page 2 autopsy PZ No 1 Yes Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2☐ ER/Outpatient 3☐ DOA 1 XYes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred After 1 or Attending 5 Pending investigation Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Thomicide the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier completely within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number TAREO ABOU-KHAMIS M.D. 24, 2005 RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 5601 LOCH RAVEN BLVD SAMARITAN HOSPITAL 6000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL Registrar

DHMH 17 Rev 1/200

HOM PSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 2103 inker 2005 Wex urran /Medical County of Death 4b. City, Town, or Location of Death 4c. 4a. Facility Name (If not institution, give street and number) Examiner FOR hesa 9. Birthplace (State or Foreign Country)

MORY And. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Funeral Days 1 M 2 F 219-44-593 Director Usual Residence of Deceder 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location na 23a or 28a-f show must be notified at 1 ☐ Yes 2 No by Funeral Director Ha 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21050 2420 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No IV Nes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. hand Mental Hygiene.
7 Is marked other than "natural", or Item
traumatic event, it is Medical Evant and 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. Whit 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's ame/Relationship (Type, Print) inker M 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tratonce. torest 111 2420 Rocks Kd MD 21050. Via linker 20b. Place of Disposition (Name of Date 20a. Method of Disposition cometery, crematory or other place)

EVALS FUNSE ACCHAPEL-1 Burial 2 Cremation 3 Removal from State 8 Forest Hill -10-05 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FOREST GSOIS OM, LIH EVANS FUNERA LCHAPEL-BOLAIG BLEWPORT XWI Ollie Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complicators that a used the left. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sepsis syndence /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an autopsy performed? Yes 2 No 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 1 Tyes Certification: To 28c. Injury at Work? 28b. Time of 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours a To the Funeral C Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 295 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHA Balair 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 1 2 2005 DHMH 17 Rev 1/2001 **ORIGINAL**

Laura Tyler 05-05378 NJM

53 <i>i</i>	8		1_ For State	State of Maryland / Department		Mental Hygie	ne	
			Registrar		rtificate of Death	Reg.	No.2005	26439
	Physici	an	Decedent's Name (First, Middle, La	151)		2. Date of Death Month	Day Year	3. Time of Death
	/Medio	cal	Laura 1	yler	1 0 0 7	August	9 2005	1000 "
	Examin	ier	4a. Facility Name (If not institution, gi		4b. City, Town, or Location of Death		4c. County of Death	
	Funaval		2501 Violet Ave 5. Social Security Number 6.3	nue Apt 801 Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birtho	place (State or Foreign
	Funeral Director			1□M 2/0 F 92 Yrs.	Months Days Hours Min.	8. Date of Birth Sept. 30, 1	1912 Ma	place (State or Foreign
	P.		Usual Residence of Decedent			Sept. Sej.		19100100
	arylar ehow	_	10a. Slate 10b. County	1 10c. City, Town or Lo	ocalion		1	0d. Inside City Limits 1 XYes 2 □ No
	ith the Marylan or 28a-f ehow se nutified at	Director	Maryland N/	Balt	imore			
	a or 2	۵	10e. Street and Number	Apt.	10f. Zip Code	10g.	Citizen of What Cour	ntry?
•	er death w Itama 23a ner must t	Funeral	11. Marital Stalus	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	nectly Yes or No-	14. Race - Americ	can Indian
(0	or itan	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
99	ours after death with the Maryla ral', or Itama 23a or 28a-f ehov Exeminer must be collined at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Bla	ack
215-0036	within 72 hours after death with the Maryland ene. then "natural", or itema 23a or 28e-f ehow he Madigal Exempler must be collined at	Completed	15. Decedent's E (Specify only highest gr	ducation 16a. Dece	dent's Usual Occupation kind of work done during most of work	kina 16b	. Kind of Business/In	dustry
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anc	Mental Parkad of atic ava	Be c	Samuel	last	E1: 706	ollo C.	oen sumane,	+
Maryland	s 1 and 2 should be filed within 72 ho if Health and Mental Hygiene. Itam 27 is marked other than "naturithan "naturithan and other traumatic avant, the Mudical	2	19a. Informant's Name/Relationship	Typo, Print) Niece) 19b. Maili	ng Address (Street and Number or Ru	ral Route Number, Ci	ity or Town, State, Zip	(Code)
S	and 2 : Balth ar n 27 Is		Mrs Lillie Mi	io Cotton 3419	Predmont A	JO Pal-	to MI	1/2//-
ē,	of Health Itam 27 other tr		20a. Method of Disposition	20b. Place of Dispo		Dale 20c	. Location - City or To	own, Stale
altimore,	permit. Pages Department of Important: If It any injury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Hemoval from State	ce National 8/16/	2005 P	alto M	4.
alti	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service/Qice	nsee () , ()	2. Name and Address of Facility	F 6.1	11 . 0	1
<u> </u>	Dep de de de de de de de de de de de de de		pslph	L. Buss 2	232 W. North Ave	Balto M	Home, P.1	T •
A.				plications that caused the death. Do not enl one cause on each line.	ler the mode of dying, such as cardiac	or respiratory arrest,		Approximale Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a HYPERTENSIVE	ATMEROSCIEROTIC	CARDION	ASCLUAR	Oliser and Death
	/Medical Examiner		Todaking in dozum	Due to (or as a consequence of):		DISETE		
.8		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):				
(d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
Ó	exec an an rial-tr		resulting in death) Last	C. Due to (or as a consequence of);				
8760	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal	•	d				
9	ntifica ng ph a as ti	Med	IF FEMALE:					
Вох	eath certifi attending for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	☐Ectopic pregnancy		23d. Date of delive	ery Day Year
0.	at the dea by the a stached fo	Physician/Me	1 ☐ Yes 2 ☐ No 9-☑Unknown	4☐Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)		WORTH	oay roa
٥.	that the ed by detac			contributing to death but not resulting in the u	nderlying cause given in Part I	23e. Did tobaco	co use contribule to the	ne cause of death?
Records,	uires l signe ld be	d by			, , , , , , , , , , , , , , , , , , , ,		2 □No 3 □ Prob	
S	w require been sig should b	Completed				24a. Was an	24h Were auto	ney findings available
Re	The lavate has	Jmp				autopsy performed	<pre>1? death?</pre>	psy findings available mpletion of cause of
Vital		0	25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2 ☐ Xth (Check only one)	No 1 ☐ Yes	2 L No
<u> </u>	d is	To B	examiner? 1 ⊈Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatier	Othor		e 6 XOther (Specif	Scene
οl	19 Ph ter th		27. Manner of Death	28a. Date of Injury 28b. Time o		28d. Describe how in		, Decire
io	Attending in death.	atlo	1 Natural 5 Pending 2 Accident investigation	n	M 1 Yes 2 No			
Division	il or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
	To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the		00- 0					
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 Certifying P	nysician: To the best of my knowledge, death	h occurred al lhe time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as st and place, and due to	taled. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month,	
	⊢ 3 ⊢ ŏ) anes	The state of the s	OCME		ugust, 9,	,
	1	1	0,00	completed cause of death (Item 23a) (Type,		A	ugust, 7,	2005
	U			310, 7D; OFFICE C		XATIMER	2, BALTING	RE, MD
100	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature				

			State of Maryland / Dep	partment of Health and Mertificate of Death	lental Hygie	•
			Decedent's Name (First, Middle, Last)	Timouto of Boath	2. Date of Death	3. Time of Death
	Physici /Medic		Willie Bernice Tabler			Day Year 5 A. MM
	Examin		4a. Eacility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			6610 Watersville Road	Mt. Airy		Carroll
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 M 2 F 73 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye April 11,	9. Birthplace (State or Foreign Country) Virginia
	land II		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1	Location		10d. Inside City Limits
	Mary First	į	Maryland Carroll Mt.	. Airy		1 ☐ Yes 2 🛣 No
	h the	lrec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	23a c	a D	6610 Watersville Road	21771	Un	nited States
	r dea	nei	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	y Fi	1 ☐ Never Married 2 【XMarried 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
8	tural	edt	15. Decedent's Education 16a. Dec	edent's Usual Occupation	166	o. Kind of Business/Industry
215	hin 7	plet	(Specify only highest grade completed) (Giv. Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of worki . DO NOT use retired)	ing	
21	od wit	Son	12th	Homemaker		Own Home
n D	d oth	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid Le Melissa	•
Z	J Men narke	ုင				
Mai	d 2 st th and 17 Is n traun			iling Address <i>(Street and Number or Rura</i> 10 Watersville Road		
Baltimore, Maryland 21215-0036 The law requires that the death certificate be executed to the stand 2 should be set and 2 should be set and 2 should be set and 2 should be detached for use as the burial-transit manual per part of the stand 2 should be detached for use as the burial-transit manual per part of the stand 2 should be detached for use as the burial-transit manual per part of the standard per part of the s		-		c. Location - City or Town, State		
ē	Pages ent of nt: If i		I LEBURAL 2 LI CIERTALION 3 LINERIOVALITORI SIALE		13, 2005	Mt. Airy, Maryland
Balti	permit. Departm Importa any Inju		21. Sign ture of Funeral Service Licensee	22. Name and Address of Facility Burrier-Queen Funer 1212 W. Old Liberty	cal Home 8	Crematory, PA
	Physician		23a Part / Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause in each ine.	nter the mode of dying, such as cardiac of		Approximate Interval Between
	/Medical		resulting in death) Due to (or as a consequence of):			
	nsit	niner	Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or injury			
,092	te be execu ysician and te burial-tra	ical Exa	resulting in death) Last C			
89	ntifica ing ph s as th		IE EEMALE:			
	the death ce y the attendi ched for use	yslclan/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
٩	ulres that n signed b lid be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Ö	aw rec s bee 2 shou	plete	Carcinha fumor of lun	g excised wi 200	24a. Was an	24b. Were autopsy findings available
Re	The la	mo;	Carcinina, head of Parcies	J. Snigery is 2002	autopsy performed 1 ☐ Yes 2 🔀	
Vital	rysiclan: Th nis certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death	h (Check only one)	
of V	Physiclan: this certific ral director,	2	1 Yes 21 No Hospital: 1 Inpatient 2 ER/Outpati			e 6 Other (Specify)
n C		on:	27. Man Fr of Death 28a. Date of Injury (Month, Day Year) 1 Vatural 5 ☐ Pending 28b. Time Injury	Work?	28d. Describe how i	injury occurred
Division	or Attendii after death. Director: A in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		28f. Location (Stree	t and Number or Rural Route Number,
Ο̈́	after after Direct	Certification;	4 Homicide determined building, etc. (Specify)		City or Town, S	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
)	To the within To the comp	Me	29b. Signature and the discertifier	29c. License number	2	Date signed (Month, Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type EVALLAN, LD. 1380 ROGRE	s, Print) WAY, ELD	ERSBU	RG, Md 21784
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 2 2005 32. Registrar's Signature	licerto .		

DHMH 17 Rev 1/2001

			4 100	partment of Health and Nertificate of Death		2005 26441
ı	Physici		Decedent's Name (First, Middle, Last) Dang Cong Tran		2. Date of Death Month	Day Year 10, 2005 3. Time of Death 2:45 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August	4c. County of Death
			Suburban Hospital	Bethesda		Montgomery
	Funeral		5. Social Security Number 212-78-2964 1 □ M 2 ☑ F 7. Age (In yrs. last birthda 1 □ M 2 ☑ F 38 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 22,	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		Feb. 22,	1917 Vietnam
	nyland thow	_	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Ba-f s	ecto	Maryland Montgomery	Bethesda		1 ☐ Yes 2 🕅 No
	with t	Funeral Director	9805 Raleigh Tavern Court	10f. Zip Code 20814		. Citizen of What Country? Inited States
	death	nera		3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
99	or its	/Fui	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc. Specify: Asian
21215-0036	hours tural',	ed by	3 ₺ Widowed 4 Divorced Year or Dates:		1.1	1102011
<u>.</u>	n "na"	plete	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	ing	b. Kind of Business/Industry
212	d with	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 Hor	nemaker		Own Home
nd	be filed within 72 hours after death with the Maryland the Hyglene. All the Hyglene. I detect the market see the world that the market see the waste, the Neufleal Examinat must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Mai	iden Sumame)
Maryland	hould d Men narke natic	2	Cang Van Vo 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Anna L		
Ma	od 2 st Ith an 27 Is r traur			iling Address <i>(Street and Number or Rur</i> 20 Ormond Road, Pot		
re,	s 1 ar		20a. Method of Disposition 20b. Place of Disposition	position (Name of	Date 200	c. Location - City or Town, State
E	Page nent o int: If iry or			ry Augu rium, Inc. 200	st 13, 5 Be	thesda, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Histman and Mental Hygiene "natural", or Itams 23a or 28a-f show any injury or other traumatic event, The Neufical Evantment must be notified at once.		21. Signature of Funeral Service Licensee		Funeral H	ome/Bethesda-Chevy
l,			23a. Part1. Ener the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Interval Between
	Enysician /Medical		Immediate Cause (Final disease or condition resulting in death) Cerebrovascular a	Accident		Onset and Death
	Examiner		Due to (or as a consequence of): Atrial Fibrilla	tion		
4	750	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	(C1011		
J	cuted nd ransit	Examiner	triat initiated events			
8760,	cate be executed by sician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
687	icate I physi s the t	dical	d			
Box (eath certific attending p	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
Ö.	ed for	sicla	in the past 12 months? 1 Yes 2 No 1 Ves 2 No	☐Ectopic pregnancy ☐Other (specify)		Month Day Year
P.O.	d by the a	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	(radahira arusa sina badi	22a Didashaa	20,420 2011 10 10 10 10 10 10 10 10 10 10 10 10
Division of Vital Records,	The law requires that the death certific tie has been signed by the attending p vage 2 should be detached for use as I	d by	Hypertension	underlying cause given in Part I.		co use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Ö	sw require s been si 2 should b	Completed	Osteoporosis		24a. Was an	24b. Were autopsy findings available
Re	: The law cate has I	mo			autopsy performed 1 ☐ Yes 2 🔀	
ita	iician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Deat	h Check onl one	12.33 22.10
<u> </u>	Physic this co	P.	1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 🖺 ER/Outpat	ent 3 DOA Other: 4 Nursing Ho		
00	ding F h. After funer	tlon:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 2 ☐ Accident investigation		28d. Describe how i	injury occurred
/ISI	deat deat ctor: / the	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm,			t and Number or Rural Route Number,
	s after s after al Dira ed in by	Cert	4 Homicide determined building, etc. (Specify)		City or Town, S	itate)
	To the Hospital within 24 hours a To the Funaral I completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To t COM	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Jus Obulletus Xel		0	August 10, 2005
	5		30. Name and address of person who completed cause of death (Item 23a) (Typ Gita Bakshi, M.D., 9406 01d Georgeto		Marvland	20814
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature at		Tally Land	
	Registr	ar	31. Date filed (Month, Day, Year) 32. Registrac's Signature 31. Date filed (Month, Day, Year)	/		

			For	State of M	arylan	d / Depa	artmen	t of H	ealth a	and M	ental Hy	/giene	005	26442
			For State Registrar			Cei	rtificate	e of L	Death			Heg. No.		
	Physici	an	1. Decedent's Name (First, Middle, L Corrinne Arnold								2. Date of D Month	Day		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, g)		4h City	Town or	Location of	of Death	Augus		2005 County of Dea	7:21P M
	Examir	ier	6220 Yorkshire	· · · · · · · · · · · · · · · · · · ·	,			iesda		/ Death			ntgome	
	Funeral			Sex 7. Ag	ge (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of B	irth	9. Bit	thplace (State or Foreign ountry)
	Director		217-28-1869	1□M 2X0F	74	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D Oct. 3.	1, 19	30 Mar	yland
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	f sho	ō	Maryland Montgo	nerv	Re	thesda								1 ☐ Yes 2X No
	r 28e	Director	10e. Street and Number	псту	<u> </u>	chebda	10f. Zip	Code				10g. Citi	izen of What C	ountry?
	th with		6220 Yorkshire T	errace			208	314				Unit	ed Sta	tes
	lems	Funerai	11. Marital Status	12. Was Decedent Armed Forces	?	.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe n, Puerto l	cify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi	
36	rs afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🖎 If Yes, Give Year or Dates:	No		1 ☐ Yes	0N 🖾	Specify:				Specify: Wh	ite
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "netural", or Items 23e or 28e-f show event, If e Medical Exambar must be mailfied at	ted	15. Decedent's 1	Education		16a. Dece	dent's Usua	I Occupa	ation			16b. Ki	ind of Business	/Industry
215	within 7; iene. 'then "n	Completed	(Specify only highest g	rade completed) College (1-4or	5+)	life.	kind of wor DO NOT us	rk done d se retired	fu <i>ring</i> mosi)	t of workir	ng			
7	filed wi Hygien sther th ent, ILe	Son	12			Homen	naker						n Home	
and	I be filed ntal Hygis ed other	Be	17. Father's Name (First, Middle, Las								(First, Middle)		Sumame)	
Maryland	should be nd Mental marked o	2	Harry James Arno 19a. Informant's Name/Relationship			19h Mailir	na Address	(Street a			La Webl		r Town, State,	Zin Code)
Ma	Ith an 27 is i		Donald Tuozzo/H			1								nd 20814
re,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other treumatic as <u>once</u> .		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nan	ne of		D	t 11,	-	ocation - City o	
m	Page nent c ant: If ury or		1 🔀 Burial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spec		St	emetery crer Mary Ceme	starv			200	5	Lauı	cel, Ma	ryland
Baltimore,	permit. Departr Importe eny inju		21. Signature of Funeral Service Lic			Be	Name an	d Addres	s of Facilit	kobe Chase	ert A.	Pump 755	hrey Fi 7 Wisco	uneral Home/ onsin Avenue
ш	20599		portuna.	· · · · · · · · · · · · · · · · · · ·	M0135								<i>3</i> 2	
ı			23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final	y one cause on each i	ine.	n. Do not ent	er the mod	e ot dylni	g, such as	cardiac o	r respiratory	arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Pancre Due to (or as			c .							7 Months
	Examiner				a conseq	derice oi).								
7	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):								1
V	ecuter and -trans	Examine	that initiated events resulting in death) Last	c										
8760,	death certificate be executed e attending physician and nd for use as the buriat-transit	icai E		Due to (or as	a conseq	dence oi):								
687	ficate physis the			_ d						-				
Вох	eath certific attending pi	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75-4:	.201					23d. Date of de	livery
-	the atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 🛣 No	1□Live birth 4□Pregnant a 9□ Unknown			⊒Ectopic pr ⊒ Other (sp						Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown			Maria and a silver of	- 4- 4- 1		- 1- 0		an Did	tabassa .		a the assume of describ?
	Se und	d by	Part II. Other significant conditions	contributing to death t	out not resi	ulting in the ti	павлунд с	ause give	en in Part I.				_	o the cause of death?
Sor	w requir been si should	etec								-	24a. Wa		-	utopsy findings available
Records,	9 4 9	Completed									auto perf	opsy ormed?	prior to death?	completion of cause of
Vital	icien: Th certificate ector, pag	0	25. Was case referred to medical	1	<u></u>				26. Place	of Death	(Check only	2X No one)	1 🗌 Ye	s 2 No
Ž	S S	To B	examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1 Inpati	ent 2 🗆	ER/Outpatier	nt 3 DC	A Othe	ar.				6 □Other (Spe	ecify)
n of			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	f 2	8c. Injury Work	at	2	28d. Describe	how injur	y occurred	
sio	Attending r death. actor: After by the fune	cati	2 Accident investigati	he	inn. At h		М		res 2□		Of Landing	/C4===4 ===	of Alembar as F	hard Courts At on hor
Division	after deat Director: In by the	ertification;	4 Homicide determine		tc. (Specify	ome, rarm, str y)	eet, factory	, office		4		wn, State		ural Route Number,
_	Hospitel	O	29a. Certifier 1X Certifying F	Physician: To the best	of my kno	wledge, deatl	h occurred	at the tim	ie, date an	d place, a	and due to the	cause(s)	and manner a	s stated.
	To the Hospitel or I within 24 hours after To the Funerel Directorpletely filled in b	edical	(Check only 2 Medical Expone)	aminer: On the basis of and manner s	of examina tated.	tion and/or in	vestigation	in my op	oínion, dea	th occurre	ed at the time	, date and	place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	ı			290	. License	number				te signed (Mon	
							D2	2967	5			Augu	st 8, 2	.005
	8		30. Name and address of person who Ralph V. Boccia,					# 4 1	.00. 1	Beth <i>e</i>	esda. N	m - 2	0817-78	347
	Sta	ite	31. Date filed (Month, Day, Year)	30 Regist				11 -7 -1					/ (
	Registr		AUG 122	JUS Marin	w h	ture								

	•	State Amend Item 2		per m	d/Depa e G&4 8	tilicat	t of H	ealth a D eath			ene • North () [251	1.2
Physicia	_	Decedent's Name (First, Middle, Las	v Vernon	J. T	ise				Mo	te of Death onth Sust S	Day 2005	Year	7:50	f Dejatho A ^M
/Medica Examine		4a. Facility Name (If not institution, give	street and number	')	-	4b. City,	Town, or	Location o			4c. County			
		Suburban Hospita					thes		2411		Mont			
Funeral Director		3/9-10-4319	9X 7. A	ge (In yrs. I	last birthday) Yrs.	If Under Months	Days	If Under	Min. (Me	te of Birth onth, Day, Y 20,	^(ear) 1918	Cou	place (State of intry) th Dak	_
and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside Ci	ity Limits
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Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Ph	ysicien: To the bes liner: On the basis and manner s	of examinat	wledge, deat tion and/or in	h occurred vestigation,	at the tim	ne, date an pinion, dea	d place, and du th occurred at th	e to the cau	se(s) and ma e and place, a	nner as	stated. to the cause(s	5)
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341		30 Name and address of person who	Nay,	11/19	Rock	Print) /E	Pi	ke, c	3-100,1	Rocki	ville,	MD	2085	72
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6.	Physici /Medio		Carrie Talbert								AUGU	ist	02,20	05	02	55AM
	Examir		4a. Facility Name (If not institution, giv	1 11			4b. City,	Town, or	Location of	Death		40	. County of	Death		
			GOOD SAMARITA		ITAL		BA	66.	MORE	- 11			NA			
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	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23e or 28e-f show event, i're Medical Examiter i wat be instiffed at	Funeral Director	11. Marital Status	12. Was Deceder Armed Forces		S. 13.	Was Deced	dent of H	ispanic Origi In, Mexican,	in? (Spe	cify Yes or N		14. Race	America White, e		
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Maryland 21215-0036	houk d Me mark matic	으	19a. Informant's Name/Relationship (Type Print)		19b Maili	na Address	(Street		nown	l Route Num	ber City	or Town. S.	tate. Zip	Code)	
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ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic evant, the Madical Examiner must be notified at once.		20a. Method of Disposition	LLCUI	20b. PI	lace of Dispo	sition (Nan	ne of	!		ate	212) 12 20c. L	ocation - C	ity or To	wn, State	
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DHMH 17 Rev 1/2001

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E E	Š	11. Marital Status	ried 2 Married	Armed Forces	?	If Ye	es, specify Cub	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Blac	k, White, etc.	igiti,
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T the state of the	Completed	12	5,102,17 (5 12)	0	,	homema	aker			own hor	ne	
of the	Be	17. Father's Name	(First, Middle, Last)					18. Mother's Nar	ne (First, Middle	e, Maiden Sumam	e)	
Ment Ment wrked wrice	2	Joseph	Clifford	Todd				Kathle	een O'Co	nnor		
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Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)	on	a. PL	ritos		Ab		orrespiratory	arrest,	Interv	oximate ral Between t and Daath
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Affer funer	o	1- Natural	5 Pending	28a. Date of Inj (Month, D	ay Year)	Injury	28c. Inju Wo M 1 □	rk?]Yes 2 □ No	200. Describe	110W IIIJury occur	100	
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DHMH 16 Rev 6/95

	.5)		1_ For State	State of Maryla					nd Me	ntal Hygi	ene	
	for		Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate	e or L	Jeath	1	Re 2. Date of Death	g. No/ 5	26446
	Physici		John Raymond							August	07 200	5 10:30 P M
	/Medic Examir		4a. Facility Name (If not institution, give 4400 Silverbrook I	street and number)	02			Location of I	Death		4c. County of De	
	Funeral	· .		_	s. iast birthday)	II Under		Il Under 24		I. Date of Birth		Birthplace (State or Foreign
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	D .		Usual Residence of Decedent 10a. State 10b. County	100 (ity, Town or Lo							
	Aaryla f sho	ō					_					10d. Inside City Limits 1 ☐ Yes XXNo
	288-	Director	MD Baltim 10e. Street and Number	ore	Owings	10f. Zip				10	g. Citizen of What	
	h with	at D	4400 Silverbroo	ok Lane, Ar	t.F102			1117				S.A.
	ems (Funeral		12. Was Decedent Ever in Armed Forces?					n? (Speci	fy Yes or No- can, etc.)	14. Race - Ar	nerican Indian,
36	s afte	by Fu	1 Never Married XXMarried	XXYes 2 □ No		☐ Yes ∑			40/10/1/	ouri, 6(c.)	Specify: T.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified a once.	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates: V 1 e	tnam 16a. Deced						Y	White
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З	ould I Men Parke Parke	은	Raymond Wise							Fleag1		
Maryland	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type								City or Town, State	
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Baltimore,	ages ant of nt: If it y or c		1 ☐ Burial ※ Cremation 3 ☐ R 4 ☐ Donation 5 ☑ Other (Specify)	emoval from State	cemetery, crem	atory`or oti	her place				•	
慧	mit. F partm portar Injur		21. Signature of Fineral Service License	ee Me	22	Name and	ory d Addres	Inc.	8/1 8/1	1/05	Baltimo	re, MD hapel P.A.
Ö	Department Department		Michael	James	110	605 R	eis	terst	cown	Rd.Ow	ings MT1	naper P.A. .1s,MD21117
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*	Physician		Immediate Cause (Final disease or condition	Atherosci								Onset and Death
36	/Medical Examiner		resulting in death)	Due to (or as a conse								
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9	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		IF FEMALE:			-						
Вох	that the death certific ed by the attending p detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe	al déath 3 🗌	Ectopic pre					23d. Date of d Month	
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time ol 9□Unknown	death 5□	Other (spe	cify)				Month	Day Year
<u>a</u>	res that t signed by be detac	h h	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying ca	use give	n in Part I.		23e. Did toba	cco use contribute	to the cause of death?
Records,	n sign						-			1 ☐ Yes	2 □ No 3 □	Probably 4 @Unknown
Ö	aw requir ts been si 2 should	lete								24a, Was an	24h Wara	autopsy findings available
	The lay	Completed							_	autopsy	prior to death	o completion of cause of
Vital		BeC	25. Was case referred to medical examiner?					26. Place of	Death (0	1 Yes 2 Check only one	□No 1⊠Ye	os 2□No
	Physic this ce	ဥ	1√7 Yes 2 No		ER/Outpatient	3 🗆 DOA	Othe	r. 4 🗋 Nursi	ng Home	5 🗌 Residen	ce 6 ∰Other (Sp	ecify) at scene
Division of	ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		lc. Injury Work			d. Describe how	injury occurred	
Sic	death death stor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	28a Place of lainer At	Name Jane et a	M		es 2⊡No		1		
2	spital or Attending ours after death. eral Director: After filled in by the funer	Certification;	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	ity)	et, lactory,	опісе		281	City or Town,	State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1□ Certifying Phys	ician: To the best of my kr	awledge, death	uenimud s	t the time	a, data and d	lace, and	I due to the cas	se(s) and manner	as stated.
	To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examin	er: On the basis of examinand manner stated.	ation and/or inv	estigation, i	in my opi	nion, death	occurred	at the time, date	e and place, and di	ue to the cause(s)
	Vith To 1	Σ	29b. Signature and title of certifier	1 10 -		29c.	License				d. Date signed (Moi	
•	/		Cabrilla	hoffer?			0.0	C.M.E.		A	ugust 08,	, 2005
	9		30. Name and address of person who con	mpleted cause of death (Ite		,	C+	t	_7		1 1 0	21 201
12	Sta	e.	31. Date filed (Month, Day, Year)	₩. Pegistrar's Sign		renn	Stre	eet, B	altı	more, M	aryland 2	CIZUL
	• Registr	- 25	AUG 1 2 2005	led and	here	W						

			1 - For State Registrar	State of Ma	aryland			nt of H te of L	ealth and M Death		giene Reg. No?	005	261.1.7
			Decedent's Neme (First, Middle, Last)							2. Date of De	ath	V	3. Time of Death
	Physici		Gerald Lee Wyatt							Month 08	07	2005	09:05a M
	/Medic Examin		4a. Facility Neme (If not institution, give s	reet and number)			4b. City	, Town, or	Location of Death		4c. Co	ounty of Deat	
			912 Truro Lane					aldor			C	har1es	
	Funeral		5. Social Security Number 6. Sex	7. Ag M 2□ F	e (In yrs. la 53	ist birthday)	If Unde	or 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)		hplace (State or Foreign untry)
	Director		218-34-9622	M 20 F	33	Yrs.				11-30	-1951	Wa	shington DC
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation						10d. Inside City Limits
	Manyl f sho	5	MD Charle	5	Wa	aldorf							1 ⊡XYes 2 □ No
	28a	rect	10e. Street and Number				10f. Z	ip Code			10g. Citize	n of What Co	untry?
	3a or	<u>-</u>	912 Truro Lane					20	0601		1	USA	
	deeth with the Maryland ms 23a or 28a-f show r runt be notified at	Funeral Director	11. Marital Status	2. Was Decedent Armed Forces?			Vas Deci	edent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No)- 14.	Race - Ame	
٥	after or its		1 ☐ Never Married 2€ Married	1X Yes 2 ☐ I		17		2√2 No	Specify:	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	S	pecify: Wh	
21215-0030	ours	d by	3 Widowed 4 Divorced	Year or Dates:		1							
ה	72 h netu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	kind of w	ual Occupa ork done d use retired	during most of work	ing	16b. Kind	of Business/	Industry
Z	within ne. hen	mp	Elementary/Secondary (0-12)	College (1-4or	5+)			Offic	,		Law	enfor	cement
N	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)	1+					18. Mother's Nam	e (First, Middle			00
yland	nntai i	Be c	Elmer Wyatt						Betty	J. Imb	oden		
Š	houk nd Me mark matic	2	19a. Informant's Name/Relationship (Ty)	oe, Print)		19b. Mailin	g Addres	ss (Street a	and Number or Rur	al Route Numb	er, City or T	own, State, 2	Zip Code)
<u> </u>	od 2 s lith ar 27 is 1 trau		Constance O. Wyat			912	Tru	ro La	ne Waldo	rf MD 2	0601		
ē,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinat must be notified at once.		20a. Method of Disposition		20b. PI	ace of Dispos	sition (N	ame of	(e)	Date	20c. Loca	tion - City or	Town, State
Baltimore,	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	moval from State	Un	iform	Serv	ices	of the	8/09/05	Ве	ethesd	a MD
	ontain inju		21. Signature of Funeral Service License	е	_nes	22	. Name	and Addres	ss of Facility				
ñ	Department of the service once.		* Stipley John	mann-	Moo	382	833 ^p	Fune Gist	ral & Cr Ave Silv	emation er Spri	Servi ng MD	1ces 20910	
	X 100		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that cause	d the death	. Do not ente	er the mo	ode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
). 1	Physician		Immediate Cause (Final disease or condition			llular	Can	cer					Onset and Death
	/Medical		resulting in death)	Due to (or as									
5	Examiner		Sequentially list conditions										
	D ==	iner	Sequentially list conditions, Tany, leading to him solutions cause. Enter Underlying Cause (Disease or injury	Due to (or as	a cons	ence of							
,	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. Due to los os		ionae of\:							
SO,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit		rosuling in oscilly and	Due to (or as	a consequ	ience or,							
8760	cate t	dical											
9 ×	eath certific attending p	/Me	IF FEMALE: 2	3c. If yes, outcome	of pregna	ncv					23	d. Date of de	livery
Box	atten for u	Physician/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 - Fetal	death 3	Ectopic Other (pregnancy specify)	'			Month	Day Year
o	by the detached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown				7, 7,					
۳.	res that i igned by be deta	/ Ph	Part II. Other significant conditions cor	tributing to death I	out not resu	ulting in the ur	nderlying	cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
Sp	uires sign	d by								1 🗆	Yes 2□	No 3□P	robably 4XXUnknown
00	w require s been si should I	Completed								24a. Was	s an	24b. Were a	utopsy findings available
Records,	he lav e has age 2	mo du								auto perf 1 Yes	ormed?	death?	completion of cause of
ta		a)	25. Was case referred to medical				_		26. Place of Dea				
Division of Vital	Physician: r this certific ral director,	0	examiner?	lospital: 1 Inpati	ent 2	ER/Outpatien	t_3 🗆 I	DOA Oth	er: 4 🗆 Nursing H	ome 5 💢 Res	idence 6	□Other (Spe	ecify)
0	ding Phys h. After this funeral di	n: T	27. Manner of Death	28a. Date of Inj (Month, Da	ury ay Yeer)	28b. Time of Injury		28c. Injur Wor	y at k?	28d. Describe	how injury	occurred	
0	death. ctor: Af	Certification:	2 Accident investigation				М	1 🗆	Yes 2 □ No				
<u> </u>	or Attendated death	tific	3 Suicide 6 Could not be determined	28e. Place of In building, e	itc. (Specify		eet, fact	ory, office			(Street and own, State)	Number or R	ural Route Number,
Ω	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune			1									
	Hosp 4 hou une	ical	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exami	ner: On the basis	of examina	wiedge, deati tion and/or in	occurre vestigati	ed at the tir on, in my o	me, date and place pinion, death occu	, and due to the rred at the time	e cause(s) a , date and p	nd manner a lace, and du	s stated. e to the cause(s)
	To the Hospital within 24 hours To the Funeral completely filled	Medical	29b. Signature and title of certified	and manner s	tated.			29c. Licens					th, Day, Year)
)	To To	-	250. Signature and title of partition				1		33105			ust 9,	
	. 0	+			1 4 E - 44	20-1-7	D-i	D.	77107		Aug	uot 7,	2003
	10			mpleted cause of				DO 1	TT 20007				
		0.00	Jimny Hwang 3800 R. 31. Date filed (Month, Day, Year)	Servoir 32. Regist	Kd . \ rar's Signa	washin: iture	gton	_DC_1	W 2000/				
	St Regist	tate	AUG 1 2	2005		W	A.	N P					

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State PER FH G847 Certificate of Death Registra MEND ITEM #7&8 PER FH G847 9/19/05 JH 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Year **Physician** -30 PM 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HMOVE ar If Under 24 Hrs. City House 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1934 Birthplace (State or Foreign Country) **Funeral** Days Hours Min 70 Months 1 M 2 DF 216-32-2500 Director Usual Residence of Decedent 10a. State 10d. Inside Çity Limits 10b. County 10c. City, Town or Location traumatic avant, the Medical Examiner must be notified at 1 Yes 2 □ No 1timore Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1503 Itams 23e Street 21218 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Neyer Married 2 Married Maryland 21215-0036 ō 1 Yes 2 No Specify: Black 3 Widowed 4 □ Divorced natural 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Health care NURSE 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil iment of Health and Mental H tant: If Itam 27 ia marked otf Be Barney James 2 10/a 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Itam 27 ia
any injury or other trau Street 1503 21218 Darlynn // 20a. Method of Disposition mo Baltimore. 20c. Location · City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 10 rematory 05 21. Signature of Funeral Service Licensee 22. Name and Address I Facility
Bradley - ASK 5h ton Funera Brad ley illow Spring 22 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Endonetria Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Be Completed by Physician/Medical use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for Year Month Dav 4□Pregnant at time of death 5 Other (specify) 0.0 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Punknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 insufficience 2 No 1 Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) Nuspi CL 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 2 Natural 5 Pending 1 ☐ Yes 2 ☐ No death 2 Accident investigation after death Director: the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide within 24 hours af
To tha Funaral D
completely filled i 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a, Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of eqtifier 29c. License number 29d. Date signed (Month, Day, Year) 0005621 8 05 Iww New 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

f. c

2 2005

31. Date filed (Month, Day, Year)

ININ

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32. Registrar's Signature

R

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State of Maryland / Department of Health and Mental Hygiene 26449 Certificate of Death Reg. No. 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 040 Hubjust 2005 /illiam lound do /Medical 4b City Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner Haven Datimore Nursily Hane If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Min Days Months Hours 1X M 2□ F 81 Yrs. ΜĎ 24 220-24-9595 Director Usuel Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 701 Edmondson Ave 21228 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours efter death vent of Health and Mantel Hygiene.

Instit if Hean 27 is marked other than "natural, or items 23, unit. if item of 15 marked other than "natural, or items 13, or other traumatic event, the Medical Experient matty or 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: ģ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Musician 12th grade Church na 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Clarence Young Sr. Anna M. Butcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 6408 Fenestra Ct., Burke, VA 22015

20b. Place of Disposition (Name of cametery, crematory or other place)

Date 20c. Location - City or Town, State Leon Owens-Nephew 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or once. Donation 5 Other (Specify) Arbutus Memorial Park 8/12/05 Arbutus, Md 22. Name and Address of Facility 2 Signeture of Funeral Service Licenses March F/H West 23a Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 **Physician** NEUMONIA Immediete Ceuse (Final disease or condition resulting in death) MON /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner ng physician and as the bunal-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or es e consequence of) P.O. Box 68760. Due to (or as e consequence of): resulting in death) Last nse nse 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Linkhown ARKINSONS Division of Vital Records. Be Completed by DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? EPENDENT MSULCA 20 No 1 ☐ Yes 24☐-No 1 Yes 26. Place of Beath (Check only one) 25. Was case referred to medical examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Menner of Death 28d. Describe how injury occurred 28b. Time of Natural 5 Pending Injury nours efter death.

neral Director: Aft
y fillad in by tha fu 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di complataly filled in Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 28595 lean sugen 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

TASNEEM LAKHANI, 7226 FAR 31. Dete filed (Month, Day, Year) 32 Registrer's Signeture AUG 1 2 2005 Registrar

											lental Hygi	_	ibic.	
		•	For State Registrar		-	Ce	rtificat	e of L	Death		Re	g. N2 0 (05	26450
	Dharaini		1. Decedent's Name (First, Middle,	Last)							2. Date of Death		Year	3. Time of Death
	Physicia /Medic	al	Viola Virgi								August	8, 20		7:45 P M
	Examin	er	4a. Facility Name (If not institution,						Location o	of Death			ty of Death	
			Genesis Heritag 5. Social Security Number	e Meridi B.Sex		e Ctr.		Dund	alk If Under:	24 Hrs.	8 Date of Birth			re Co. place (State or Foreign
	Funeral Director		232-36-1496 Usual Residence of Decedent	1 □ M 2 X OXF	76	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Feb. 11,	Year) 1929	Cou	Virginia
	land ow	-	10a. State 10b. County		10c.	City, Town or Le	ocation							10d. Inside City Limits
	Mary e-f sh	tor	Maryland	Baltimo	re			E	dgeme	re				1 □ Yes 27□No
	th the	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of		1.0
	ath wi	ral	2607 Manor Av							219			ed St	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-f show amy injury or other treumetic event. The Marchal Examination matches notified at once.	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed F	2 N O	10.S. 13.	Was Deced If Yes, special 1 ☐ Yes			gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		ack, White,	
Ö	hours turel',	d by	3 ☐Widowed 4 ☐ Divorced	Year or I	ates:	163 Door	dent's Usua	al Ossuss	ation.		.	16b. Kind of I	W.	hite
-5	in 72 n "net	Completed	(Specify only highest	grade completed,		(Give	kind of wo DO NOT u	rk done d se retired	turing mosi)	t of work	ng	IGD. KING OF	ousiiiess/ii	idustry
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b	al Hyg	Be C	17. Father's Name (First, Middle, L.	ast)							(First, Middle, N		me)	
ylai	Menta Menta arked	10	Robert Clegg			_					V. Plate			
-	nd 2 sho alth and i 27 is me r treume		19a. Informant's Name/Relationshi Mrs. Debra Gill		ughter		ng Address 9 Man				Mere, Ma			o Code) 219
ore,	es 1 a of Hea litern		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	Domesti from	20	b. Place of Dispo cemetery, cre	osition (Nar matory or c	me of other place	θ)		Date 2	20c. Location	-	
Ē	Page ment ent: If ury or	1	'4 □Donation 5 □ Other (Spe		State	Oak Law			, ,	12/2	005	Balti	more,	Maryland
Baltimore,	permit. Departe Import any inj once.		21. Signature of Funeral Service Li	censee							Home of			nc. 1222
-			232 Part1. Enter the disease, or of shock, or heart failure. List of	omplications that	caused the d									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PA	RKI	NSO	NS	D	ISE	A	SE			8 YEARS
	/Medical Examiner		resulting in death)	Due to	(or as a con	sequence of):								
	LXammer	_	Sequentially list conditions,	b. Due to	for as a con-	sequence of):								
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,	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a con	sequence of):								
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89	rtifica ng ph	Medi	IF FEMALE:											
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		birth 2 ☐ f nant at time	etal death 3[⊒Ectopic pi ⊒ Other (sp						ate of deliv lonth	ery Day Year
P.O.	that the	/ Ph	Part II. Other significant condition	s contributing to	death but not	resulting in the u	ınderlying o	ause give	en in Part I.		23e. Did tob	acco use cor	nterbute to t	the cause of death?
Division of Vital Records,	w requires been sign should be	Completed by	HYPERT	ENS	NON						1 □ Ye	s 2 No	3 🗌 Pro	bably 4 □Unknown
000	e taw requ has been : je 2 should	plet									24a. Was ar		. Were auto	opsy findings available ompletion of cause of
m		Com									perform	No No	death? 1 ☐ Yes	2 🗆 No
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year CHESTER ANTHONY ZALESKI August 9,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Gilchrist Center Baltimore Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months 213-14-9722 84 Yrs Director August 3,1921 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8917 Yvonne Ave. 21236 Be Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "r any injury or other traumatic event, the Mad any injury or other traumatic event, the Mad and once. Elementary/Secondary (0-12) College (1-4or 5+) OWNER TAVERN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES ZALESKI MARY ANN SLEBSAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodosia Heilker (Daughter) 8917 Yvonne Ave. Perry Hall, Maryland 21236 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State GREEN MOUNT CREMATORY 8/11/05 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligens Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) methicillin-resistant. Staphlococcus **Physician** weeks /Medical Due to (or as a consequence of): endo c Arditis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): Certification: To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No itus 1 ☐ Yes 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

2005

August

State

31. Date filed (Month, Day, Year) AUG 1 2 2005 Registrar

29a, Certifier

29b. Signature and title of eartifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23aPIT, 25, perMe. C846_8/II/05 TT 1- For Amend Item 8 per FH, G846, 08/19/05dhb
Registrar
Registrar
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 3:30 P^M 18, Margaret A. Benchoff June 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner St. Catherine's Nursing Center Emmitsburg ederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of B03/25/12 9. Birthplace (State or Foreign (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 3€3€ Director Yrs. 331-34-5576 12 Emmitsburg, MD Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "netural", or items 23e or 28e-1 show other treumetic event, it a Maxical Expansion must be notified at PΔ Franklin Blue Ridge Summit 1 Yes & No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11738 Furnace Rd 17214 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after on Mental Hygiene i marked other then "netural", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: 3 ₩idowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Topper Adelaide Little and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an item 27 Is Joanna T. Buhrman, Daughter PO Box 762, Blue Ridge Summit, PA 17214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) St. Mary's Cem. | 6-25-05 Fairfield, PA 22. Name and Address of Facility JL Davis Funeral Home 21. Signature of Funeral Service Licensee 23a. Parky Figher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. 12525 Bradbury Ave., Smithsburg, MD 21783 Approximate Interval Between Onset and Death Immediate Cause (Final letastatic adenocarcinoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Directo (or as a consequence of) Examine WANTEDICAL EXAMINER use as the burial-transit that initiated events CERTIFICATION APPR resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Vunknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? Hypertensive arteriosclerotic autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No cardiovascular disease Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1X Yes 2 Vie Other: 4 Volume 15 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Certification; 28c. Injury at Work? After Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D0058356 06-21-2005 M-D. 30. Name and address of person who completed use of d ath (Item 23a) (Type, Print) , 3375 Cartisle Pd., Gardier, PA (7324 David L. plov M.D-Year) 31. Date filed (Month, Day, 32. Signature State

DHMH 17 Rev 1/2001

Registrar

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permit. P Departm Importar any Inju		21. Signa use of Funeral Service Licer Once 23a. Part 1. Enter the disease, or com shock, or heart failure. List only	Moo Moo	the death. Do	6633	Old Alexan		Road Clin	Approximate Interval Between
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d be filed antal Hygic ced other cevent, I	To Be Co	17. Father's Name (First, Middle, Last)	eio		Casiii		r's Name <i>(First, Middle</i>		
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23a or 26	Funeral Director	10e. Street and Number 12605 Sub Station	n Road		10f. 2	Zip Code 20601		10g. Citizen of What	-
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Funeral Director			□M 2\(\text{\text{\$\text{\$\text{\$F}\$}}}\) 36		Yrs. Month	s Days Hours	Min. (Month, Da	ay, Year)	country) shington DC
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Physic /Med Exami	çal	Tammy 4a. Facility Name (If not institution, give	Sue e street and number)	В	rummitt 4b. Cit	ty, Town, or Location o	AUGUST	5, 2005 4c. County of D	9:37P.
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	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death					
	/Medic	al	Amanda How		kwalter	- antion of Death	July	26 2005 4c. County of Death	12:40 p M					
	Examin	er	4a. Facility Name (If not institution, give street ar		4b. City, Town, or L			_						
			Crofton Convalescent (5. Social Security Number 6. Sex	Center 7. Age (In yrs. last birtho	Crofton		8. Date of Birth	Anne Arun						
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	or 28	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	untry?					
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	and and a salth n 27		Thomas Buckwalter, sor		West Irvin									
ore	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal	cemetery	isposition (Name of crematory or other place)		ite 20	c. Location - City or 1	Town, State					
altimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		`4 ☐Donation 5 ☐ Other (Specify)	Trinit	y Church Cen		30-05 U	pper Marlb	oro, MD					
Ball	Depart Import any in		21. Signature of Funeral Service Licensee		22. Name and Address				20736					
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				on each line.	t enter the mode of dying,	such as cardiac or	respiratory arrest	,	Approximate Interval Between Onset and Death					
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	To To Com	Σ	29b. Signature and title of certifier		29c. License	number	29d	Date signed (Month	, Day, Year)					
•					DE	5/1028		1-21-0)>					
	8		30. Name and address of person who completed	cause of death (Item 23a) (T	ype, Print)	210 771	Maria.	nolie m	D.21401					
			31. Date filed (Month, Day, Year)	32. Registr ø s Signature	yery Aur.	Stc.231	MINICE	12017	V. C1 401					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 4:45 P M Harold July Edwin Boesch, 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Asbury Solomons Nursing Center Calvert 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Yrs 579-07-2890 Washington, DC Director Usual Residence of Decedent iled within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 23e or 28a-f show rest be notified at 1 Yes 2 No Funeral Director Maryland Calvert Solomons 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11450 Asbury Circle #409 20688 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ir then "neturel", or Items If a Madical Examiner in Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛛 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be find and Mental H Paul Raymond Boesch Ethel Swaine ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health an 940 Ellendale Drive, Towsen, Maryland 21286 Kathryn B. King (Daughter) other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages permit. Pages Department of I Importent: If it eny injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 07/24/2005 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Port Republic, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYELODT Physician FAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-t nding physician Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? lor Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIJEASE 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 2 □ No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending Injury 1 Natural 5 Pending after death.
I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident the Funeral Directors of filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29c. License number 29b. Signature apd title of certifier D26350 30. Name a d address of person who completed cause of death (Item 23a) (Type, Print) PRINCE FREDERICK, WEI GEL 0/1/2 31. Date filed (Month, Day, Year) 32. Registres Signature State 2005 General JUL 27 Registrar

Maryland 21215-0036

P.0.

Division of Vital Records.

Macec Boston Jr.
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		1. Decedent's Name (First, Middle, Last)	alth Dept	Certificate of	Dealli	2. Date of Death	g. N62 0 0 5	8. Firme of Deale
Physicia /Medic		Maceo Bost	on, Jr.			July &	Day 2005	0038 M
Examin		4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, o	r Location of Death	7	4c. County of Deat	h lai
		NOTTH Arundel Hos 5. Social Security Number 6. Sex	7. Age (In yrs. last bin	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Anne A	hplace (State or Foreign
Funeral Director		238-54-3236 1X M 2□F		Yrs. Months Days	Hours Min.	Dec. 18	Year) Co	th Carolina
D		Usual Residence of Decedent	10c. City. Town					10d. Inside City Limits
farylar show	or	10a. State 10b. County						1 Yes XXNo
the h	Director	MD Anne Arundel 10e. Street and Number	Han	10f. Zip Code		10	g. Citizen of What Co	ountry?
th with		1601 Deer Meadow Cour	t	2107	6		USA	
tems	Funeral	Armed I	ecedent Ever in U.S. Forces?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
irs aft	by F	1 ☐ Never Married 2 ⚠ Married 1 ☒ Yes If Yes, 0 Year or	s 2□No Give Dates: 1958-81	1 ☐ Yes 2 💢 No	Specify:		Specify: I	Black
72 hours after death with the Maryland natural', or Items 23a or 28a-f show	eted	15. Decedent's Education (Specify only highest grade completed	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	nation	ina 10	6b. Kind of Business/	Industry
vithin ne. han	Completed	Elementary/Secondary (0-12) College	(1-4or 5+)				DOD	
filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last)	ре	puty Direct		e (First, Middle, M	DOD aiden Sumame)	
And be Aental	To B	Maceo Boston			Nancy	Smith		
and h		19a. Informant's Name/Relationship (Type, Print)		. Mailing Address (Street			-	
1 and Health Health Health Iher tr		Shelley Boston (Wife) 20a. Method of Disposition		001 Deer Mea		-	r, MD 2107	
ages int of h t: If ite y or of		1 Disposition 3 □Removal from 4 □Donation 5 □Other (Specify)	m State cemeter	ry, crematory or other place: Hill Cemet	C0)	_	Asheville.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: I flem 23a or 28a-f show any injury or other traumatic event, the Machel Examination until at 2000.		21. Signature of Funeral Service Literage	72020	22. Name and Addre Hardest				NO
permi Depa Impo any ir		198 J. Chi		12 Ridge	ly Avenue	, Annapo.	lis, MD 21	401
33,65		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or	t caused the death. Do no each line.	not enter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	robuste	Myocarc	lial (rterchi	9A.	Miss
Examiner		A	o (or as a consequence	ace phalo	pally			Mini
it d	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence	of):				7
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death certificate I attending physi	Physician/Medic	IF FEMALE:						
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that the death cer ed by the attendir detached for use	iyslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unk	gnant at time of death known	5 Other (specify)				
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w requires that s been signed to should be det		Colon lancor	His	100 of 10	107 mil	1 ☐ Yes	2 2 N o 3 □ Pr	obably 4 Unknown
4 2 0	ompleted	Hypertension		tiller pla	cerent	24a. Was an autopsy perform	prior to o	itopsy findings available completion of cause of
	e Col	Dasetes 25. Was case referred to medical			00.00	1 ☐ Yes 2	Vo 1 □ Yes	2 No
Physician: r this certific ral director,	To Be	examiner?	Inpatient 2 ☐ ER/Ou	utpatient 3 DOA Oth	200	h (Check only one ome 5 ☐ Residen	nce 6 ⊡Other (Spe	cify)
ding Phys		27. Manner of Death 1 X Natural 5 □ Pending (Mo		Time of 28c. Injur	rk?	28d. Describe how	v injury occurred	
Attending r death.	icatl	2 Accident investigation 3 Suicide 6 Could not be	ce of Injury - At home, fa		Yes 2 □No	28f Location /Stre	eet and Number or Ru	iral Route Number
after after Dirac	Certification:	4 Homicide determined buil	Iding, etc. (Specify)	am, street, laddry, onice		City or Town,		ar riodio ivanibor,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only 2 Medicel Exeminer: On the	he best of my knowledge	e, death occurred at the til	me, date and place,	and due to the cau	use(s) and manner as	stated.
the H thin 24 the F mplete	Medical	one) and ma	anner stated.	29c. Licens			d. Date signed (Mont	
7 × 7		Deore CW	ih 9 1	70 04	1365		July 22	, 2005
		30. Name and address of person who completed ca	use of death (term 23a)	(Type, Print)	al Drive	e, Glen	Burnie	MD, 210%
Sta		31. Date filed (Month, Day, Year) 32.	Registrar's Signature	H A. A.				
Registr	ar	שוני מי ש למחו	your s	- BOOKE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4:24 A M July 2005 George T. Booth, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Laurel Regional Hospital Laurel 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs 8, Director 72 Wash., 578-42-8733 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 □ No Completed by Funeral Director Mitchellville Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 United States 12603 King Gate Court death 14. Race - American Indian, Black, White etc. Airican 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1X Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filled within nent of Health and Mental Hygiene. ant: If item 27 is markad other than ury or othar traumatic event, It a M. Elementary/Secondary (0-12) College (1-4or 5+) 12th Mail Clerk Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Brooker George T. Booth, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4338 D St., S.E. Wash., DC Deborah D. Jackson- Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ▼Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Department of Important: If any injury or once. 7/30/2005 Glenwood Cemetery Wash., DC 21. Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 lloar 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate a se (Final disease or o ition resulting in death) Respiratory Failure Physician /Medical Due to (or as a consequence of): Examiner Acute Respiratory Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Pneumonia Due to (or as a consequence of): Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, peq 1 Yes 2 No 3 Probably 4 Unknown Acute Renal Failure Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Sepsis page 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Medical 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title 29d. Date signed (Month, Day, Year) 20 DH3351 121/05 "Greenhelt Rel, Sit 4-15, Golge PKM) who completed cause of death (Item 23a) (Type, Print) 6201 OKWARA IKechi 31. Date filed (Month, Day, Year)

State Registrar

JUL 2 9 2005



			1 - For State Registrar	State of N	Maryland	-	artment rtificate					Reg. I	ne 20()5	264!	58
H	Physici	an	1. Decedent's Name (First, Middle	^{le, Last)} Bloomfi	014		Jr.				2. Date of I		Day 200	Хеаг	3. Time of 0	Death M
	/Medic Examin		Ester 4a. Facility Name (If not institution				4b. City, To	own, or	Location of	of Death	oury		4c. County			141
	Examili	E	Prince Georg		-				er1y						George	S
	Funeral Director		5. Social Security Number 244-58-7972 Usual Residence of Decedent	6. Sex 7 124 M 2 ☐ F	Age (In yrs. Id 66	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under: Hours	24 Hrs. Min.	8. Date of 8 0 8 - 2.4	Birth Day, 1 ^Y a	38	9. Birth	place (State or	Foreign
	land ow		10a. State 10b. County	,	10c. City	, Town or Lo									10d, Inside City	/ Limits
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	th with the 23a or 28	ai Director	10e. Street and Number 711 Rittenho	ouse St. N	W		10f. Zip C	2	0011	L		10g. (Citizen of V	v u Sa	ntry?	
920	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturat", or items 23a or 28a-f show event, the Modical Exercities mast be rutified at	I by Funerai	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes Give	\$? ∃No		Was Decede f Yes, specif 1 ☐ Yes 2				ecify Yes or I Rican, etc.)	No-		k, White,	can Indian, etc. lack	
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ylar		To B	Ester F	31oomfield		Sr.			Fanr	nie			Wall	-		
, Maryland 21215-0036	d 2 shoth and the and the modern traum		19a. Informant's Name/Relations Clayton Bloom	ship (Type, Print) nfield/ Br		231.	5 Alt	amo	nd Numbe	er or Rura P1.	SE #]	ber, City . 02	w or Town, Wash	State, Zip	C 2002	20
Baltimore,			20a. Method of Disposition XXXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5)		_ ce	ace of Dispo emetery, cren surre	natory or oth ction	er place C e	em .	7-30	Date) – 2005	C1	Location - intc	n,	MD	
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			23a. Part LEnter the disease, o shock, or heart failure. List	r complications that caus t only one cause on each	ed the death	. Do not ent	er the mode	of dying	g, such as	cardiac o	or respiratory	arrest,			Approximate Interval Betw	een
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Division	l or Attending after death, Director: After I in by the fune	Certification;	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At hos etc. (Specify	me, farm, str					28f. Location City or T			er or Rura	al Route Numb	∋ <i>r</i> ,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai C	29a. Certifier 1 🔀 Certifyin (Check only one)	ng Physician: To the be Examiner: On the basis and manner	of examinati	vledge, death ion and/or inv	occurred at restigation, in	the time	e, date and inion, deat	d place, th occurr	and due to the	e cause e, date a	(s) and maind place, a	nner as s and due to	tated. the cause(s)	
	To the within To the Compl	Me	29b. Signature and title of certifie	or C			29c.	License	number			29d. [Date signed	(Month,	Day, Year)	
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R	(5)		30. Name and address of person Ophnell Cumb	who completed cause o erbatch	f death (Item	416°C	Print) entra	11 /	Ave.	, La	andov	er,	MD 2	2078	5	
	Sta Registr		31. Date filed (Month, Day, Year, JUL 2 9		strar's Signat	ure	£)									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 JULY Month Year **Physician** 28 9:25 AM VIAR /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY WICOMICO NURSING HOME WICOMICO If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Months 51-12-5396 South CArolina Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or Items 23a or 28a-f show other treumatic event, I'm Medical Examinar integral by 1 Yes 2 No Director WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2180 nder Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced BLAC Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 10 WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental DAU 2 ynthia WhitA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationshi (Type, Print) Department of Health a Importent: If item 27 is any injury or other tre once. 1 Rentur NI PLACE 20b. Place of Disposition (Name of cometer, crematory or other place)

SPUNG HILL MEMBERS Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GITWest. IsabellaSt. 5A13bury, MO2801 BENNIE Smith uneral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NASSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTHYROIDISM 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s LYSPHAGIA CARDIOVALULA rmed? 200 No DISTAST certificate MHGRISCLEROTIC 1□ Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No hours after death. Director: / investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a To the Funerel D To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0060515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHESHA THIMMARAYAPPA M.D. 614 EASTERNSHORE DR SALISBURY MD 21804 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State JUL 2 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item/23a, 27, 28a-f, permE, G846, 8/15/05 TT

			1 = For Registrar	State of Ma		partment of F ertificate of			giene 005	26460
	, n		1. Decedent's Name (First, Middle, Las	t)				2. Date of De Month	ath Day Year	3. Time of Death
	Physici /Medi		Deborah	Jane	Char	les		August	1 000=	4:00 A M
	Examir	ier	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	1	4c. County of Dea	ath
			Memorial Hospita		- University of the state of	Cumber 1 Year	and If Under 24 Hrs.	10.0 (5)	Allegany	
9	Funeral Director		5. Social Security Number 6. S	□M 2XF	e (In yrs. last birthda) Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da		rthplace (State or Foreign ountry)
	A s		225-78-9045 Usual Residence of Decedent		51			05/14/19	54 Wash	ington, DC
	yland		10a. State 10b. County		10c. City, Town or I	ocation	-			10d. Inside City Limits
	a-f s	cto	WV Mineral		Ridge	ley				1 ☐ Yes 2 TYNo
	ith th	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	ath w	rail	Route 3 Box 677			2675	3		USA	
	ar de tama	nue	11. Marital Status	12. Was Decedent I Armed Forces?		. Was Decedent of H If Yes, specify Cub.	lispanic Origin? (S _i an, Mexican, Puert	pecify Yes or No Rican, etc.)	- 14. Race - Am Black, Whi	
36	within 72 hours after death with the Maryland one. then "nature!", or itsms 23s or 28s-f show the Madical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 🔯 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ሺ h If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Specify:		Specify:	White '
21215-0036	thou sture	ed	15. Decedent's Ed		16a, Dec	edent's Usual Occup	pation		16b. Kind of Business	
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212	d with giene	E	12	2) +)	Beautician	l		Beauty Sho	
	at Hy t other	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
Maryland	Ment Ment arkec	ဂ္	Douglas	Sincla			Unkno			
lar	2 sho		19a. Informant's Name/Relationship (7						er, City or Town, State,	Zip Code) .
	l and tealth m 27		Ralph W. Charles / hu	sband		e 3 Box 677	A, Ridgele	y, WV 267		
Baltimore,	it of h it of h if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		1	ematory or other place	'		20c. Location - City of	
Ħ	rtmer rtant njury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			nd Crematory	1 '			d, Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "naturel", or itsma 23s or 28a-f show any injury or other traumatic avant, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Licen					•	Funeral Home	•
	e was		23a. Part1. Enter the disease, or comp	olications that caused	the death. Do not e				, ,	Approximate
1 8	Physician		Immediate Cause (Final	one cause on each in	10.					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		ne intoxic a consequence of):	ation				
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90,	oe exection a	E	resulting in death) Last	Due to (or as	a consequence of):					
58760,	cate t	dical	•	d						
_			IF FEMALE:	23c. If yes, outcome	of pregnancy				004 0-4-44	Para
Вох	death certif e attending ed for use as	Physician/Me	in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy	,		23d. Date of de Month	Day Year
o.	0 0 0	ysi	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	9□ Unknown						
٦,	The law requires that the ste has been signed by the page 2 should be detache	by Pl	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
Records,	quire an sig uld b							1 🗆 1	res 2□No 3□P	robably 4 DUnknown
ဝွ	aw requi	Completed						24a. Was	an 24b. Were a	utopsy findings available
Ä	The tav	E O							rmed? prior to death?	completion of cause of
Vital		Be C	25. Was case referred to medical examiner?				26. Place of Dea			
of V	d is	To	1 ∑ Yes 2 □ No	Hospital: 1 🔲 Inpatie	nt 2 XER/Outpatie	ent 3 DOA Oth	er: 4 🗆 Nursing H		dence 6 Other (Spe	
	De ter		27. Manner of Death 1 □ Natural 5 □ Pending	Produce of Injur	y Year) Find Injury	of 28c. Injur Wor	y at k?	28d. Describe h	now injury occurred u	nk
sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	8/1/2005		/ A	Yes 2 No			
Division	or Attendater deatl	Certification:	4 Homicide determined	building, etc	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (S City or Tox	Street and Number or R vn, State) Rt 3 1	ural Route Number,
	lospitel or Attendir 4 hours after death. Funeral Director: At ely filled in by the fu		29a Centifier 1 ☐ Certifying Ph	Scene	of my knowledge, des	the against at the fire			ey W.VA	
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only one)	iner: On the basis of and manner sta	examination and/or i	nvestigation, in my o	ne, date and place. pinion, death occu	red at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mon	th, Dey, Year)
	- > - 0		Yashill Their	hall us in		0.0	C.M.E.		August 3,	2005
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type				,	
			tamek E. So	whan, mD			reet, Ba	ltimore.	Maryland,	21201
	Sta		31. Date filed (Month, Day, Year)	2005 Segistra	ar's Signature	20			, ,	
	Registr	ar	1100 1 2	CUUIT Pina	hat he	All As				

Reg. No. U 0 5 26461
Date of Death 3. Time of Death
Month Day Year (15.15 p M
4c. County of Death
Charles
Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
ig. 20,1929 Pennsylvania
10d. Inside City Limits
1 🛣 es 2 🗆 No
10g. Citizen of What Country?
U.S.A.
Yes or No- 14. Race - American Indian, in, etc.) Black, White, etc.
Specify: White
16b. Kind of Business/Industry
U.S. Government
rst, Middle, Maiden Sumame)
fman
oute Number, City or Town, State, Zip Code)
s Road, Maryland 20616
2005 20c. Location - City or Town, State
vice Alexandria, Virgini
Home, P.A. 20640 L., Indian Head, Md.
spiratory arrest, Approximate Interval Between Onset and Death
Oliset and Death
ne
23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death?
23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy prior to completion of cause of
1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No heck only one)
1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No heck only one) 5 Residence 6 Other (Specify) Describe how injury occurred
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1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N

			For State Registrer		of Marylar	-	artment o				ene g. 2.0 (05	26462
	Physici	ian	Decedent's Name (First, Middle, I							ate of Death onth	Day	Year	3. Time of Death
	/Medi	cal	Donald Patrick 4a. Facility Name (If not institution, of		umbarl		4h Cihi Tour	n, or Location of		ly 26	7		12:05 P M
4	Examir	ner	Shady Grove Ad		,	al		m, or Location o ville	or Death			nty of Death ntgome	erv
	Funeral			. Sex	7. Age (In yrs.		If Under 1 Ye		24 Hrs. 8. Da	te of Birth		9 Rinthe	place (State or Foreign
	Director		214-42-5043	1 ⊠ M 2□F	6:	1 Yrs.	Months Da	ys Hours	Min. Sep	ot. 21	, 1943	Wash	ington,DC
	and W		Usual Residence of Decedent 10a, State 10b, County		10c. Ci	ty, Town or Lo	ncation					1	IOd. Inside City Limits
	Maryli f sho	ō	Maryland Montgo	morn		Rocky							1 A Yes 2 □ No
	h the Maryland r 28a-f show r notified at	Director	10e. Street and Number	мегу		ROCK	10f. Zip Cod	de		10	g. Citizen o	f What Cour	ntry?
	h with 23a or st De	ai D	34 Waddington	Court			20850	0			US.	A	
	ems erms	Funerai	11. Marital Status	12. Was Dec Armed F	cedent Ever in U	J.S. 13.	Was Decedent	of Hispanic Ori	igin? (Specify Y	es or No-		ace - Americ	
36	s afte , or It	by Fu	1 Never Married 2 Married	1 X Yes If Yes. G	2 No		1 □ Yes 2 🔀 i			,,		<i>™</i> White	
8	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examinar must be notified at		3 ☐ Widowed 4 ☑ Divorced 15. Decedent's	Year or I	Dates: 1300		dent's Usual Oc	cupation		1	6b. Kind of		
15	n "na Nedio	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed		(Give	kind of work do DO NOT use re	one during mos. ntired)	t of working				,
212	d with giene er tha	E O	Elementary/Secondary (0-12)	3	(1-4or 5+)	Mar	nager			P	rinti	ng & ations	5
Б	al Hy d other	Be	17. Father's Name (First, Middle, La						er's Name (First		aiden Suma	ame)	
yla	Meni Meni Marke	ဥ	Clarence Anthon		y, Sr				a Neide				
Maryland 21215-0036	d 2 sh h and 7 is m traum		19a. Informant's Name/Relationship Jennifer Chaney/		or	1			or or Rural Rous d, Beth				Code)
	1 and Health em 2		20a. Method of Disposition	Daugne	20b. I	Place of Dispo	sition (Name of	f	Date		Oc. Location		own. State
nor	ages ant of t: if it y or o		1X□ Burial 2 □ Cremation 3		State	cemetery, crei	natory or other aven Ceme	place)	August	1,			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examinat must be and 6.		* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		// 0				2005				ng,Maryland
B	permit Depar Impor any in		+ Huan &	9. Ye	liler	Fr 50	ancis 3	J. Coll ersity	ins Fun Blvd, W	eral ., Si	Home :	Inc Sprinc	, MD 20901
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that	caused the dear					-		235	Approximate Interval Between
	Physician	П	Immediate Cause (Final disease or condition		onary F	ibrosis	;					5	Onset and Death Years
	/Medical Examiner		resulting in death)	a	(or as a consec								y carb
	Lxammer	L	Sequentially list conditions.	b									
	led Isit	je je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	quence or):							
	be executed ician and burial-transif	Examiner	that initiated events resulting in death) Last	c Due to	o (or as a consec	quence of):							
8760,	cate be executed physician and the burial-transit			d.									
9	certificate iding phys ise as the	ledicai											
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnation		Ectopic pregna	ancv				ate of delive	
E	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of c		Other (specify				N	Month	Day Year
Δ.	t t by		Part II. Other significant conditions	s contributing to	death but not res	sulting in the u	ndarking cause	anyon in Part I	2	3a Did tobs	acco usa co	ntribute to th	ne cause of death?
Records,	Se 50	Completed by	Idiopathic Throm				noonying occuso	givor att att.	. [-	1 🗆 Yes			ably 4 Unknown
Sor	> 0 0	ete								4a. Was an			psy findings available
Re	e la has je 2	dmo								autopsy perform	ed?	prior to cor death?	mpletion of cause of
Vital	ician: Th certificate rector, pag	e e	25. Was case referred to medical	1				26 Place	of Death (Che		X No	1 🗆 Yes	2 No
Ž	Physician; r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ½ No	Hospital:	Minpatient 2□	ER/Outpatien	t 3 DOA	Othor	rsing Home 5			ther (Specifi	y)
n of			27. Manner of Death 1 X Natural 5 □ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	28c. lr	njury at Work?			v injury occu		
Division	Attending redeath. sector; After by the fune	Certification:	2 Accident investigat 3 Suicide 6 Could not	ion			M 1	1 □ Yes 2 □ I					
Σį	or At ifter d Direct in by	il i	4 Homicide determine	28e. Plac	e of Injury - At h ding, etc. (Specil	ome, farm, str fy)	eet, factory, offi	ice	28f. Lc	cation (Stre ity or Town,	et and Num State)	nber or Rura	l Route Number,
ш	pital ours a leral I		29a. Certifier 1 1 Certifying I	Physician: To th	a bast of my kno	awledge death	a annumed at the	a timo data an	d along and du	- to the			1,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Ex	aminer: On the	basis of examina oner stated.	ation and/or in	vestigation, in π	ny opinion, deal	th occurred at t	he time, dat	e and place	nanner as si e, and due to	the cause(s)
	To the Mithin To the Comple	Me	29b. Signature and the of certifier	1 /	/		29c. Lice	ense number		29	d. Date sign	ed (Month,	Day, Year)
	10		1/ er/4.	Ar	line	h.	D2	26540			T 7	26 2	1005
	1		30. Name and address of person wh				Print)				_	26, 2	
			Carl I. Schoen				Frederi	ick Road	d, #213	, Gai	therst	ourg,	MD 20877
	Sta Registr	ate rar	31. Date filed (Month, Day, Year)	2005	Registrar's Signa	St. Sp	all						

			1 - For State Registrar	State of Ma	aryland	•		t of H			ental Hy	Reg. No.	005	2	6463
	Physici	an	Decedent's Name (First, Middle, Last)								2. Date of De Month	Day	Ye		3. Time of Death
4	/Medi		Giulio Leonardo C 4a. Facility Name (If not institution, give s				4b Ciby	Tour or	Location of	f Doath	July	27,	2005 County of E	No ath	9:30a M
4	Examir	ner	5610 Wisconsin A			i	-		Chas				Montg		v
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (<i>In yr</i> s. <i>I</i> as	t birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Bir (Month, Da				e (State or Foreign
	Director		297.28.3496	M 2□F	89	Yrs.	Months	Days	Hours	Min.	Sept.2	9, 1	915	Mila:	n, Italy
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation							10d	. Inside City Limits
	Maryl 4 sho	ŏ	MD Montgome	ry		evy C								1,00.	1 ☐ Yes XXNo
	r 28a	Director	10e. Street and Number		L		10f. Zip	Code	-			10g. Citi	zen of What	Country	?
	th wit	ai D	5610 Wisconsin Aven	ue #604				20	815				U.S.A	•	
	r dea	Funeral		12. Was Decedent I Armed Forces?		13. V	Vas Deced Yes, spec	lent of His	spanic Orig	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	-	14. Race - A	merican Vhite, etc.	
36	s afte		1 ☐ Never Married 2XXMarried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give	No		☐ Yes 2		Specify:			- 1	Specify:		
9	72 hours after death with the Maryland haturel', or Itame 23s or 28s-1 show dies! Examiner must be notified at	Completed by	15. Decedent's Educ	Year or Dates:		16a. Deced	ent's Usua	I Occupa	tion			16b. Kir	nd of Busine	ess/Indus	stry
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7	filed within Hygiene. other than "	Con	5	+		Bioch	emist	:				В	ioche	mist	ry
nd	0 = 0 ¥	Be	17. Father's Name (First, Middle, Last)	•					18. Mother		(First, Middle,				
Z	should be nd Mental markad o umatic eve	6	Umberto Canto			40. 14.00					Nella P				
Maryland 21215-0036	permit. Pages 1 and 2 should b Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic or		19a. Informant's Name/Relationship (Ty) Gabriella Cantoni								Route Number				20815
ē,	Heal Ham 2 tam 2		20a. Method of Disposition	, WIIC		e of Dispos					ate		cation - City	-	
Ë	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		etery, crem • Com		ner piace	1	T11 T 37	29, 20	Ω5 Δ	1 ovan	dria	77Δ
Baltimore,	Departm Departm Importa any inju		21. Signature of Funeral Service License	ЭӨ	, 110			d Addres			eph Gaw				
<u>m</u>	89 5 8	(75	1	2		51	30 Wi	scon	sin A	Avent	ıe NW	WDC	2001		
	Physician /Medical		23a. Part1. Enter the disease, or compli- shock, or beart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Congest	tive H	leart			, such as c	cardiac o	r respiratory a	rrest,		Int	oproximate terval Between nset and Death year
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	tinsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	nce of):									
8760,	ate be executed thysician and the burial-transit		that initiated events cresulting in death) Last	Due to (or as	a consequer	nce of):							-		
387	icate t physic	edical	d	l	- · · · · · · · · · · · · · · · · · · ·			-							
Box 6	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal de	eath 3 🗆	Ectopic pre					2	3d. Date of Month	delivery Da	y Year
P.0	at the de by the a	hys	9 🗆 Unknown	9□ Unknown							_				
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Seco	e law r has be je 2 sh	ompieted									24a. Was autop	sy	prior	to comple	findings available etion of cause of
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Ž		o Be	25. Was case referred to medical examiner? 1 \sum Yes 2\sum No	ospital:			207.00				Check onl o				
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ion	불곡출호	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	/ Year)	Injury	М		? es 2 □ N						
Division	after des after des Director d in by th	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc.	ury - At home c. (Specify)	e, farm, stre	et, factory,	office		2	8f. Location (5 City or Tox		Number or	Rural Ro	oute Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: K completely filled in by the f	edical C	29a. Certifier 1 XCertifying Phys (Check only 2 Medicel Exemin	sicien: To the best of ner: On the basis of and manner sta	examination	edge, death and/or inv	оссипеd а estigation,	at the time in my opi	e, date and inion, death	place, a	nd due to the od at the time,	cause(s) date and	and manner place, and o	as stated	d. e cause(s)
	To the within 2.	M	29b. Signature and title of certifier	Λ				License				29d. Date	signed (Ma	onth, Day	/, Year)
}			1 homen	- Sack	2/	40	M	D125	68			Ju1y	29, 2	2005	
	10		30. Name and address of person who con								arrange.				
			Thomas Sacks, M.D. 31. Date filed (Month, Day, Year)	3301 N	ew Mer	xico i			WDC	20	016	40.51	D/1110000		
	Sta Registr		31. Date filed (Month, Day, Year) 9 20	32. Rivgistra	ACL S	1 Sag	BASIN	7							

ney	Cannoi	1	1 - For State Registrar	State of Ma	arylan		artmen			and M	,	giene Reg. No	005	261.6	1.
1		0	1. Decedent's Name (First, Middle, Last,)							2. Date of De	ath		3. Time of Dea	ath
	Physici /Medi		Rodney Woodro	w Cannon	1						Month July	28.	2005	18:30	М
100	Examir		4a. Facility Name (If not institution, give		_				Location o	f Death		4c. Co	ounty of Death		
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	Funeral Director			M 2□F	47	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da May 25	y, Year)	9. Birth Cou	place (State or Fo. ntry)	reign
	ש		Usual Residence of Decedent								May 25	1930	Mar	yland	
)	arylar ehow	_	10a. State 10b. County	.1	10c. City	, Town or Lo								10d. Inside City Li	
5	Ne M	Director	MD Dorches	ter					ew Ma	rket				1 Tes 2 2	INO
(with t	Dir	10e. Street and Number 5627 Belle Aire	Poad			10f. Zip		631				of What Cou	ntry?	
)	death with the Maryland ms 23a or 28s-1 ehow crount be notified at	by Funerai	11. Marital Status	12. Was Decedent 8	Ever in U.:	S. 13. \	Was Deced			in? (Spe	cify Yes or No Rican, etc.)		SA Race - Ameri	can Indian.	
9	or Ite	Fur	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 ☑ N	No	i	fYes, spec I□Yes 2			, Puerto I	Rican, etc.)		Black, White,		
8	ural',		3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:					Specify:			Sp	ecify: wh	ite	
<u>4</u>	n 72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation e com <i>pleted)</i>		16a. Deced	lent's Usua kind of wor DO NOT us	k done di	urina most	of workii	ng	16b. Kind	of Business/Ir	ndustry	
12	withi	dwo	Elementary/Secondary (0-12)	College (1-4or 5	(+)	_	n reso	,		nage	r	olog	tronic	a mfa	
ğ	e filed I Hyg other	BeC	17. Father's Name (First, Middle, Last)			110110,1	1 1000	1			(First, Middle,			s iiirg.	
<u> ar</u>	uld be Menta Menta rrked rrked	To B	Howard Rodney C	annon					Gen	evie	ve Burt	on			
Maryland 21215-0036	and lema		19a. Informant's Name/Relationship (Ty			19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Numbe	er, City or To	wn, State, Zij	Code)	
ره (ه	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mental Hygiene. Department of Healin and Mental Hygiene. Beginner of Healine 27 is marked other than "natural; or flems 23a or 28a-1 show any injury or other treumatic event, the Medical Examination in the notified at once.		Howard Rodney Canna 20a. Method of Disposition	on fath		5703 ace of Dispo	Ceda:	r Gro	ove R		East Ne				
Baltimore,	ages nt of h t: If ite		1 ☐ Burial 2 🗹 Cremation 3 ☐ P	Removal from State	CE	emetery, cren	natory or ot	her place					ion - City or T		
Ħ.	artme artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur • inFuneral Service License	90	pall	sbury				8/1/0	omas Fu		sbury,		_
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	Physician and /Medical Examiner the prize reast	ai Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequi	rence of):	France	_ /	odi					Interval Betweer Onset and Death	
P.O. Box 687	t the death certifi by the attending I ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of the control o	2 □ Fetal time of de	death 3 ath 5	Ectopic pre	ecify)			CO. Dida	THE PLANE	Date of deliver	Day Year	
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Division of Vital Record	w requir been si should	Completed by	He Contactor We (notiovas	ela	- 0.	confl)			24a. Was	-		psy findings availa	_
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ā		BeC	25. Was case referred to medical					_	26. Place	of Death	Check only or	2□No	es	2□No	_
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טופ	ding Ph h. Alter th funeral	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury		Bc. Injury Work?			8d. Describe h	ow injury o	curred		
Sic	Attending Physician: r death. sector: After this certific by the funeral director.	icat	2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	28a Riago of Inju	n. At hor	m a farm atte	M		es 2□N		Of Leasting (C	·		10	
<u>≥</u>	after deat Director: d in by the	Certification:	4 ☐ Homicide determined	28e. Pface of Inju building, etc	. (Specify)))	et, ractory,	ОПІСӨ		2	City or Tow	n, State)	umber or Hura	al Route Number,	
	To the Hospital or Attenwithin 24 hours after deal To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1☐ Certifying Phys (Check only only 2☐ Medical Examir	sician: To the best of ner: On the basis of and manner stat	examinati	vledge, death on and/or inv	occurred a estigation,	it the time	o, date and nion, death	place, a	nd due to the o	ause(s) and late and pla	manner as s ce, and due to	tated. o the cause(s)	
	To the within 2 To the complet	ž	29b. Signature/and title of certifier				29c.	License	number		Ä	29d. Date si	gned (Month,	Day, Year)	
	1		Corper	M				0.	C.M.1	Ξ.		July 2	29, 200)5	
			30. Name and address of person who co	mpleted cause of de		111		Stre	et, I	Balt:	imore,	Maryla	and 212	201	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 1 200	32 Ameistra	r's Signati		with I								

				1 - For State Registrar	tate of Maryland		t of Health and N e of Death	Mental Hygier	0000	20105
		Physic		1. Decedent's Name (First, Middle, Last) $Edward$	Da	nwkins		2. Date of Death Month	Day Year	3. Time of Death
		/Medi Examii Funeral Director		4a Facility Name (If not institution, give stree 5. Social Security Number 6. Sex 17-01-1383	7. Age (in yrs. las	Tal 3	Town, or Location of Death 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea Dec. 22, 1	lc. County of Death 9. Birthr Court 1913 Mar	place (State or Foreign try)
		D.		Usual Residence of Decedent 10a. State 10b. County Anne		Town or Location		-33,-33,-		10d. Inside City Limits
		h the Mar r 28a-f s	Funeral Director	Maryland Arunde 10e. Street and Number	1	Cocke	ysville Code	10g. C	Citizen of What Cour	1 Tyes 2 No
		eath wit ns 23a o	eral D	10528 Lakespring	Way Was Decedent Ever in U.S.		21030		USA	
K1115	9000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. mportant: if item 27 is marked other than "naturel", or items 23a or 28a-f show myn jnury or other treumatic avent, if a Medical Examinat must be notified at 2008.	Þ	1 Never Married 2 Married 1	was Decedent Ever in U.S. Armed Forces? I Yes 2 No If Yes, Give Year or Dates:	If Yes, spec	ent of Hispanic Origin? (Sp ify Cuban, Mexican, Puerto ⊇∰No Specity:	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White, Black, Ck	
200	21215-0036	within 72 hours ane. than "naturel", e Medical Exa	Completed	15. Decedent's Educatio (Specify only highest grade cor Elementary/Secondary (0-12)	on mpleted) College (1-4or 5+)	life. DO NOT us	k done during most of work e retired)	ting 16b.	Kind of Business/Ind	,
(al Hygie f other	Be Co	17. Father's Name (First, Middle, Last)	D 1	Lon		e (First, Middle, Maide		6
V	ıryla	12 should be filed v h and Mental Hygie 7 Is marked other t reumatic avent, III	10	William 19a. Informant's Name/Relationship (Type, F	Dawkins Print)	19b. Mailing Address	Mary (Street and Number or Rur		nson	Code
ward	, Ma	es 1 and 2 and 1 a		Larry Dawkins/nep	hew	10528 Lal	cespring Wa	ay Cockey	sville,	MD 21030
0	Baltimore, Maryland	Pages 1 lent of H nt: If ite ry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State St.	ce of Disposition (Nameletery, crematory or of John UM(c Cem. 8/2/		Location - City or To	wn, State
للإ	Balti	permit. Pages : Department of H Important: If its any injury or of		21. Signature of Funeral Service Licensee **Deadip a. L.**	Sewell	22. Name and		well Fun	orel Her	me 020678
•		Physician /Medical Examiner		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	ons that caused the death. use on each line. Due to (or as a consequent	Flyi	d Over)	or respiratory arrest,		Approximate Interval Between Onset and Death
	,8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequent	HTN	1 Strong		College	
	P.O. Box 6	To the Hospitel or Attending Physicien: The law requires that the death certific thin 24 hours after death. To the Funds to trificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Med	in the past 12 months?	yes, outcome of pregnanc □Live birth 2 □ Fetal de □Pregnant at time of deat □ Unknown	eath 3 Ectopic pre			23d. Date of delive Month	ry Day Year
	rds, P	w requires that been signed I should be det	by	Part II. Other significant conditions contribu	ting to death but not resulti	ng in the underlying ca	use given in Part I.	23e. Did tobacco	use contribute to th	
	Division of Vital Records,	ding Physicien: The law re n. After this certificate has ber funeral director, page 2 sho	Completed					24a. Was an autopsy performed 1 Yes 2 No	24b. Were autop prior to con death? 1 □ Yes	osy findings available inpletion of cause of
	fVit	nysicier ais certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospit	tal: 1 Inpatient 2 ER	VOutpatient 3□ DQA	Other	n (Check only one) me 5 ☐ Residence	6 □Other (Specify)
	ion o	nding Pt ath. r: After the e funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ta. Date of Injury (Month, Day Year)	Bb. Time of 28 Injury M	c. Injury at Work?	28d. Describe how inju	iry occurred	
	Divis	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28	Be. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory,	office	28f. Location (Street a. City or Town, Stat	nd Number o <i>r Rur</i> al e)	Route Number,
		ne Hospit 24 hour ne Funere	edical ((Check only 2 Medical Examiner: (n: To the best of my knowle On the basis of examination and manner stated.	edge, death occurred a n and/or investigation, i	t the time, date and place, n my opinion, death occurr	and due to the cause(s ed at the time, date an	s) and manner as sta d place, and due to	ated. the cause(s)
)	To th within To th	M	29b. Signature and title of certifier	2.7.6.	29c.	License number	29d. Da	ate signed (Month, E	Day, Year)
		3		30. Name and address person who complet	ted cause of death (Item 2	a) (Type, Print)	1.00		()) // ./ .
		Sta	te	31. Date filed (Month, Day, Year)	32. Registre's Signature		20	ioralonoc)	Severa	of Cost
		Registr	ar	AUG - 1 2	MAG MANAGE	LT- LOSA				

		1 - For State Registrar	State o	of Marylan	-	artment of l				giene	005	264	66
		Decedent's Name (First, Middle	e, Last)	-					2. Date of Dea Month	ath Day		3. Time o	of Death
Physi /Mac	ician dical	James	Earl	De	ean				July	26	2005	5:30	рМ
Exam		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town,	or Location	of Death	-	4c. (County of Deat	h	
	*	7290 Southern				Owing					Calver		
Funera		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birtl (Month, Day)_	v, Year)	Co	hplace (State	or Foreign
Directo	or	218–34–7389 Usual Residence of Decedent	X	67	113.				July 1	, 19	38 Mar	yland	
land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside (City Limits
Mary Fed	ţ	MD Calve	rt			Owing	s					1 ☐ Ye	s 2 ∑ No
ith the Marylan or 28e-f show	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Co	ountry?	
th wit	ai D	7290 Southern	Maryland	Blvd.		20	736				USA		
r dea	Funerai	11. Marital Status	12. Was Dec Armed F	cedent Ever in U orces?	.S. 13.	Was Decedent of f Yes, specify Cul	Hispanic Orban, Mexical	igin? (Spec n, Puerto R	rify Yes or No- lican, etc.)	1	4. Race - Ame Black, White		
or it	by Fu	1 Never Married 2 Mar	If Vas G	² XNo ive No	ĺ	1 ☐ Yes 2 💢 No					Specify: 1.7h	ite	
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27 n 27 n 37 n 37 n 3 n 3 n 3 n 3 n 3 n 3 n 3	Completed	(Specify only highe	nt's Education est grade completed,		(Give	kind of work done DO NOT use retire	durina mos	st of workin	g	100. 14	14 01 003111633/	industry	
withing the man	Jwo	Elementary/Secondary (0-12)	College	(1-4or 5+)	self	employed	excar	vator		e	excavat	ing	
ild & I.K. I e filed withir il Hygiene. other than	O	17. Father's Name (First, Middle,	Last)		1				(First, Middle,	Maiden S	Sumame)		
Should be filed with a Mental Hygiene, i marked other than immatic event, the market other than a matic event, the market of the market ovent, the market ov	To B	James Farl	Dean	ı			G	ussie	Ma	rie	Sm	ith	
S S S E E	-	19a. Informant's Name/Relations			19b. Mailir	ng Address (Stree			Route Numbe	r, City or			
E, ING 1 and 2 Health a tem 27 is		Margaret E. De	an, wife			So. MD		, Owi	ngs, MI	20	736		
Dattimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Demoval from	20b. F	Place of Dispo cemetery, crei	sition (Name of natory or other pla	ace)	Da	ate	20c. Loc	cation - City or	Town, State	
cattifications. Pages partment of I portant: If its y injury or o		`4 □ Donation 5 ★ Other (S			. Memo	rial Gar	dens	07-29	-05	Dunk	cirk. M	D 207	54
mit.	once.	21. Signature of Funeral Service				2. Name and Addr							
0 997	a	William	~ K: (Poss		ausch Fu					nas, M		
		23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that t only one cause on	caused the deat each line	h. Do not ent	•				rest,		Approxima Interval Be Onselvano	etween
Physicia	_	Immediate Cause (Final disease or condition	_ a^	meta	Nath	5 UW	ng c	alla	er			2/20	2000
/Medica Examine	-	resulting in death)	Due to	(or as a conseq	uence of):	,	9					DID	U
LAdillille		Sequentially list conditions,	b	/									
pe lsi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a conseq	uence or):								
xecut and Il-trar	xan	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):								
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ficate ficate phys	edicai		d										
= 0,10	N/W	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		-				2	3d. Date of del	ivery	
that the death cered by the attendir detached for use	hysician/M	in the past 12 months?	4⊡Preg	birth 2 Feta Inant at time of c]Ectopic pregnand] Other <i>(specify)</i> _	cy 				Month	Day	Year
at the day the tached	hys	9 Unknown	9□ Unki	nown									
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w requires been sign	leted k								1 2 (Y	′es 2[]No 3∏Pr	obably 4	Unknown
law requires that the as been signed by the 2 should be detached.	piet	1							24a. Was autop		24b. Were au	topsy finding	s available
0 - 0	Compl								perfor	med?	death?	2 No	04455 5.
vician: The certificate rector, pag	a)	25. Was case referred to medica	ıt				26. Place	e of Death	(Check only o				
Physic this ce al direc	To B	examiner?	Hospital: 1]Inpatient 2	ER/Outpatier	nt 3 DOA	ther: 4 🗆 N	ursing Hom	e 5 X Resid	ience 6	Other (Spe	cify)	
ding Phy After this funeral o		27. Manner of Death 1 Natural 5 Pendi	28a. Date (Mo.	of Injury nth, Day Year)	28b. Time o Injury	f 28c. Inju	ury at ork?	2	8d. Describe h	ow injury	occurred		
VISION OI VILA Attending Physician: or death. ector: After this certific by the funeral director,	atic	2 Accident invest	igation			M 1[Yes 2	-					
or Att	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 288. Place	e of Injury - At hiding, etc. (Special	ome, farm, sti fy)	eet, factory, office	•	2	8f. Location (S City or Tow		i Number or Ru	ırai Route Nu	mber,
the Hospital or hin 24 hours afte the Funeral Dir									- 1 - 1 - 1				/
Hosp 24 ho Fune tely fi	edical		ng Physician: To the Examiner: On the	basis of examina									(s)
To the Hospital or Attending Physician: To the Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director,	Med	29b. Signature and title of certific	A	nner stated	7	29c. Licer	nse num <u>b</u> er	, ,	<u> </u>	29d. Date	signed (Mont	Day, Year)	
Vill To			Jailal	1		D	-17	601	4	7/	28/05		
		30. Name and address of person	who completed cau	use of death (Iter	n 23al /Tun-	Proti				· ·	,		
\Re		CO. Ivaline and additions of the spirit	2 9 2005	MD	200) (1990)	WILLIAM	1 , 1	N					
	State	31. Date filed (Month, Day, Year) 32.	Registras Signa	ature								
Regi		JUL	2 9 2005	Heren	w K	Sporte	•						

			For State Registrar	State of M	arylan	•	artment of H				giene Reg. N.C. (005	26467
			Decedent's Name (First, Middle,	Last)						2. Date of Dea	ath		3. Time of Death
	Physici			ecil Duck	0++					July 2	25, 2	200^{Year}	5:15 p ^M
	/Medic		4a. Facility Name (If not institution,				4b. City, Town, or	r Location o		our,		ounty of Deat	
	Examin	er				+11+O		tove.				omers	
	-		Eastern Corre 5. Social Security Number 6			last birthday)	If Under 1 Year			8. Date of Birt		9. Birt	hplace (State or Foreign
н	Funeral Director		213-78-4998	1 <u>M</u> M 2□F	45	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day 8/6/1	y, Year) 959	Co	untry) MD
			Usual Residence of Decedent				L			0/0/1	333		1110
	/lanc		10a. State 10b. County		10c. City	y, Town or Lo	ocation						10d. Inside City Limits
	Mar	to	MD Ca	lvert			Dun	kirk					1∭XYes 2□No
	r 288	by Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citizer	n of What Co	untry?
	3a o	Q E	2224 Harley	Drive			207	54				USA	
	death ms 2	ere	11. Marital Status	12. Was Decedent		S. 13.	Was Decedent of Hi If Yes, specify Cuba		gin? (Spe	ify Yes or No-	14.	Race - Ame	
(0	r He	Fūr	1 ☐ Never Married 2 Married	Armed Forces? d 1 ☐ Yes 2 🔀					i, Puerto F	rican, etc.)		Black, White	e, etc.
සි	urs a		3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 💢 No	Specify:			Sp	ecify: B	lack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-1 show the Madical Examinat must be multied at	Completed	15. Decedent's	Education		16a. Dece	dent's Usual Occupa	ation	t of workin		16b. Kind	of Business/	ndustry
"	hin 7	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	lite.	DO NOT use retired	during most d)	OF WORKIN	9			
7	d with	mo;	12	000g0 (1		l F	House Pa	inte	r		Home	Impr	ovement
ğ	othe othe	Be C	17. Father's Name (First, Middle, La	ist)				18. Mothe	r's Name	(First, Middle,	Maiden Su	imame)	
Maryland	12 should be filed within in and Mental Hygiene. 7 is marked other than "Iraumatic event, Itu Med	To B	George Franci	s Duckett				Li	11ia	n Rob	inso	n	
ar.	shound N	_	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street a	and Numbe	er or Rural	Route Numbe	r, City or To	own, State, Z	(ip Code)
Š	and 2 ealth a n 27 is		Debra Duckett	/Wife		2224	Harley	Dri	ve.	Dunki	rk. N	MD 20	754
ē,	Hea Hea tem othe		20a. Method of Disposition	,	20b. P	lace of Dispo	sition (Name of natory or other place			ate		tion - City or	
Baltimore,	Pages nent of I ant: If its ury or o		1 ZABurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			•	rial Gdn	· 1	/20	/2005	Dunk	irk	MD
≢	artme ortan injur	. 1	21. Signature of Funeral Service Lic		ΙΟ.								
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita Medical Examinar must be notified at once.		G. Wo	W.			2. Name and Addres D Box 43						, P.A.
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	d the death	n. Do not ent	er the mode of dying	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
	Pnysician :		Immediate Cause (Final			W. V. T. F.	Failur	10					Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as	a consequ	uence of).	Facilo 1					-	days
le.	Examiner			Tntv	acto	ible	Pain						ueeks
	450	e	Sequentially list conditions, if any, leading to immediate	Quality (or as			Post					-)
	uted d ansit	౼	lam, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events	Lung	7 6-1	anc.e	LY .						months
<u>.</u>	be executed sician and burial-transit	Examiner	resulting in death) Last	Due to (or as									1100
8760,	ate be executed hysician and the burial-transit	dicail		d									
687	licate physi s the l	pe		U									
	The law requires that the death certific tie has been signed by the attending p tage 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d	. Date of deli	verv
Вох	atter for a	clar	in the past 12 months?	1☐Live birth 4☐Pregnant a			Ectopic pregnancy Other (specify)					Month	Day Year
oj.	the d the ched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
ሷ	res that the de igned by the a be detached t	P	Part II. Other significant conditions	s contributing to death b	ut not resu	ulting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
ds	uires I sign Id be	d by								1 🗆 Y	es 2 N	lo 3∏Pro	bably 4 Unknown
Records,	w requ	Completed								040 1460		Idh Mass su	Landing and labor
š	has has ge 2 s	du								24a. Was a autop: perfor	sy med?	prior to death?	topsy findings available ompletion of cause of
=		S									2 00	1 🗆 Yes	2 No
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	t lea-iteli			l Out		of Death	(Check only or	7e)		
5	Physician: r this certifica ral director, I	ို	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatio		ER/Outpatien		4 LI Nui		e 5 🗌 Resid			WInfirman
Division of	ng P	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	Work			Bd. Describe h	ow injury o	ccurred	
<u>0</u>	tending F death. tor: After the funera	cati	2 Accident investigat					Yes 2□N	No				
Ĕ	or Att	ij	3 Suicide 6 Could not 4 Homicide determine	ed 28e. Place of Inj	ury - At ho c. (Specify	me, farm, str	eet, factory, office		2	Bf. Location (S City or Town		lumber or Ru	ral Route Number,
	rs af	S											
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	of my know	wledge, death	occurred at the time	ne, date and	d place, ar	nd due to the c	ause(s) and	d manner as	stated. to the cause(s)
	the Him 24	edi	one)	and manner st									
	with To T	2	29b. Signature and title of certifier				29c. License	e number		2	9d. Date si	igned (Month	, Day, Year)
			S.A. Roz	a Jololi			200	60	115		71:	25/2	005
	5		30. Name and address of person of	o completed cause of c	leath (Item	23a) (Type,					-	- 10/1	
	J		Seyed A.	Jalali 1	00	EW+	Carroll	St.	Sal	isbun	2. M	0 21	801
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	s Signat	ture 🔑	de de						
	Registr	ar	JUL	32. Registr	Week.	1 15.	your						

		•	1 - For State Registrar	State of Maryl			of Health a	and Me	ental Hy	giene	C 10 1	5 2	754	68	
1	7		Decedent's Name (First, Middle, Last	")	· · · · · · · · · · · · · · ·				2. Date of De				3. Time	of Death	_
vę.	Physicia		Jeanne Marie Dul	insky					July 2	7, ^{Day}	05	ear	6:30	рδ	A
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Tow	n, or Location of	of Death		4c.	County of	Death			
		-	Collington Episcop	al Life Care	<u>.</u>	Mitc	hellvil	.1e		I	rinc	e Ge	orge	's	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In)	vrs. last birthday)	If Under 1 Yo			8. Date of Bir (Month, Da	rth			ice (State		n
	Director		082-14-6485	□M 2X F 84	Yrs.	Wildright St	2,5		Nov. 1						
	D >1		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ocation						10	d. Inside	City Limit	 s
	anyla shov	'n	Maryland Prince G			11ville								s 21 N	
	he M	Director	10e. Street and Number	eorge s	micene.	10f. Zip Coo				10a Citi	zen of Wha	at Countr	rv?		_
	with 1			1 4 4 4 0 1 0		207					S.A.	at 000/11	v.		
	eath	Funerai	10450 Lottsford Ro	12. Was Decedent Ever i	n U.S. 13.			ain? (Spec	cify Yes or No		14. Race -	America	n Indian,		
	ter d	'n	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1X Yes 2 No			of Hispanic Orig Cuban, Mexican	, Puerto F	lican, etc.)		Black,	White, e	tc.		
986	urs af	þ	3 X Widowed 4 □ Divorced	If Yes, Give WW Year or Dates:	II	1☐ Yes 2🛣	No Specify:				Specify:	Wh	nite		
21215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28e-f show Jigal Exantrer must be collified at	Completed	15. Decedent's Ed	cation	16a. Dece	dent's Usual Oc	ccupation one during most	e of workin		16b. Ki	nd of Busir				_
215	hin 7 9. an "n Med	pie	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use re	etired)	i or working	g						
2	ad with	NO.		4	Sec	retary					cking	Con	npany		_
p	al Hy al Hy soth	Be (17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)				
<u>Ja</u>	Ment Ment arkec	2	Charles T. Latimer	c					Sween						_
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		19a. Informant's Name/Relationship (7)	ype, Print)		•	reet and Numbe			-					
	and ealth n 27		Jennifer Johnson,				venue,					207			_
Baltimore,	of Hi of Hi if iter		20a. Method of Disposition 1 Burial 2 Cremation 3	1	 b. Place of Disponentery, createry, createry 	osition (Name o matory or other	r place)	Da	ate	20c. Lo	cation - Ci	ty or low	vn, State		
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Specify		Metropolit				/2005					nia	_
alt	Departi Departi Import any inj once.		21. Signature of Eureral Service Licent	596			ddress of Facilit								
<u> </u>	205 20		+autt	py			timore.				ille,		207 Approxim		
*	Physician /Medical Examiner	her	23a. Part . Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Congestiv Due to (or as a con Due to (or as a con	e Heart sequence of):				Toopiidory a				Interval B Onset and Wee	etween d Death	
68760,	ficate be executed physician and is the burial-transit	edicai Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a con	sequence of):										_
.O. Box	that the death certificate be took the attending physic detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3[⊒Ectopic pregn ⊒ Other (specif					23d. Date of Month		y Day	Year	
s, p	es Iha igned I be det	by P	Part II. Dther significant conditions of	entributing to death but not	resulting in the u	inderlying cause	e given in Part I.	•	23e. Did	tobacco u	se contribu	ute to the	cause of	f death?	
rds	i so		Chronic Obstructi	ve Pulmonary	Disease	3			1 K)	Yes 2	□ No 3	☐ Proba	ibly 4	Unknow	n
Record	e law has to 3e 2 s	Completed	SIP Right Pneumon		on small	l cell			24a. Was auto perfe		prid	re autop or to com ath? Yes 2	sy finding	s availab cause of	Θ
of Vital	i cian: Th certificate rector, pag	O	lung cancer in 199	70			26. Place	of Death	(Check only						_
>	Physician: this certific ral director,	0 8	examiner? 1 ☐ Yes 2🏋 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3□ DOA	Other: 4K Nu	ursing Hom	ne 5 ☐ Res	idence	6 □Other	(Specify))		
0		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Yea	z) 28b. Time o	of 28c.	Injury at Work?	2	8d. Describe	how injur	y occurred				
jo	Attending F r death. ector: After by the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		,,,		1 Yes 2	No							
Division	l or Atten after deat Director: in by the	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st	reet, factory, of	fice	2	8f. Location ((Street an wn, State	d Number)	or Rural	Route Nu	ımber,	
Ö	spitel or Attendours after death ours after death eral Director: filled in by the	Certification:													
	Hospitel 24 hours a Funeral I		(Check only 2 Medical Exam	ysician: To the best of my iner: On the basis of exam)(s)	
	the the	Medicai	one)	and manner stated.	7	29c 1 i	cense number			29d. Dat	e signed (i	Month D	av. Year		_
	With Con		29b. Signature and title of certifier	(11/					1						
			- was ryle	Sell !			22780			Ju1	y 29,	200)5	-	
R	(19) 1/2		30. Name and address of person who of Peter M. Schissle	/			ter Dri	ve #4	:30 . Gr	reenh	elt.	Mary	y1and	1	
	Sta	te	31. Date filed (Month, Day, Year)	#2 Pagistrar's S	ion ature -		TOL DIT				,		,		_
	Registr		JUL 2 9 2005	Server 1	K Lieu	D									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JULY 20°05 28 GLENNA SUE DORROUGH 7:13P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** 4b. City, Town, or Location of Death 17117 HOSKINSON ROAD POOLESVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. FEB 944 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🗹 F 213-42-6624 61 Yrs Director VA Usuel Residence of Decedent the Maryland Show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Wedical Examinating the profiled at MD MONTGOMERY POOLESVILLE 1 PYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 17117 HOSKINSON ROAD 20837 USA death by Funeral 11. Marital Status . Was Decedent Eyer in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "na any injury or other treumatic event, the Madis once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LEASE ANALYST 12 MARRIOTT CORP. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ARCHIE GLENWOOD TOLBERT MAMIE LUCILLE NESTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 20837 19a. Informant's Name/Relationship (Type, Print) CHONTELLE HOCKENBERY/DAUGHTER 19300 HEMPSTONE AVE., POOLESVILLE, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State PLEASANT HILL CEM. 8/2/05 ` 4 ☐ Donation 5 ☐ Other (Specify) MONROVIA, MD 21. Signature of Tineral Service Licen 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Wendlarinna /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause that Indanying Cause (Disease or injury ner Due to (or as a consequence of): certificate be executed the burial-transit Exami and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical as use a IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe Completed 1 Yes 2 No 3 Probably 4 Wonknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 2 No 2 No 1 Yes 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pendina after death.
Director: Aft investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined hours after within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and tyle of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 6382Y 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marish rand 10605 CONCORD ST., #300, KENSINGTON, MD 20895 31. Date filed (Mogth, Registrar's Signature 1 2005 State Registrar

			1 - For State Registrar	State of I	Marylan	-	artmen rtificat			and M	lental Hy	giene Reg. NØ (105	261.70
	Physici	an	1. Decedent's Name (First, Middle, La	,							2. Date of De Month July	Day	200̈́5̈́′	3. Time of Death
	/Medic Examir		James Leroy F1 4a. Facility Name (If not institution, give	_	ər)		4b. City.	Town, or	Location of	of Death	Jury	30, 4c, Co	unty of Deat	12:00 P.M
	LXUIIII	101	Calvert Memorial						reder			1	vert	
	Funeral Director		5. Social Security Number 443–05–2841 Usual Residence of Decedent	Sex 7. X□M 2□F	Age (In yrs. I 95		If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da July 5	1910	9. Birti Ok I	nplace (State or Foreign unity) anoma
	be filed within 72 hours after death with the Maryland nat Hygiene. 9d other then "naturel", or Itams 23a or 28a-1 show event, the Medical Eva offer must be mutilled at	Director	10a. State 10b. County Maryland Calvert 10e. Street and Number		1	, Town or Lo						10g. Citizen	of What Co	10d. Inside City Limits 1 Yes 2 No
	ath wi	ral	5040 Sandy Point	· · · · · · · · · · · · · · · · · · ·			206						d Stat	ces
9800	ours after de ral', or Itams Era , in et n	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married **XXWidowed 4 ☐ Divorced	12. Was Decede Armed Force 1 X Yes 2 [If Yes, Give Year or Date	□No	_	Was Deced f Yes, spec 1 ☐ Yes		spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	1 _	Race - Ame Black, White ecify: Whi	e, etc.
15-0	nin 72 h n "natu Medical	Completed	15. Decedent's E (Specify only highest gr	ade completed)		16a. Deced (Give life. I	ient's Usua kind of wor DO NOT us	l Occupa rk done di se retired)	tion uring most	of worki	ng	16b. Kind	of Business/I	ndustry
212	filed with Hygiene other the	Com	Elementary/Secondary (0-12) 12th	College (1-4c	or5+)	Poli	ce Of	fice	r			Law E	nforce	ement
Maryland 21215-0036	2 should be file and Mental Hy is marked oth raumatic event	To Be (17. Father's Name (First, Middle, Last James H. Fry						Lizz	ie M	(First, Middle,			
	nd 2 shallth and 27 is m		19a. Informant's Name/Relationship (Bille Jo Buckmas		hter)	19b. Mailin 5040	g Address Sand	(Street a	^{nd Numbe} int R	r or Rum d.,	l Route Numbe Prince	er, City or To Frede	wn, State, Z rick,	ip Code) MD 20678
altimore,	Pages 1 ar		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 ↑ 4 □ Donation 5 □ Other (Special Content of the Co	Removal from Sta	te ce	ace of Dispo emetery, cren outeau	natory or of	her place		/04/	05		ion · City or 1	own, State Oklahoma
Balti	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Lice	nsee	00 542	22	. Name and	d Address	s of Facility	Rau	sch Fu	neral	liome,	
8760,	death certificate be executed Wedical e attending physician and for use as the burial-transit	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	PM	ence of):	מטי	√ <i>1</i> -						Interval Batween Onset and Death 2
O. Box 6	death certifi e attending ed for use as	hysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of de	death 3 [Ectopic pre		_			23d.	Date of delive Month	rery Day Year
rds, P	9 0 0	by P	Part II. Other significant conditions of					use giver	n in Part I.			_	_	the cause of death?
I Records,	The ate h page	Completed	Corregistiv	e Hean	FA	tur-	•						tb. Were autoprior to condeath?	opsy findings available ompletion of cause of
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:							(Check only o	ne)		
ō	ding Phys n. After this funeral di	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, E		R/Outpatient 28b. Time of Injury		lc. Injury : Work?	4 🗀 1101	2	ne 5 Resid 8d. Describe h			(y)
DIVISION	i Site	Certifica	3 Suicide 6 Could not be determined	28e. Place of I	njury - At hon etc. <i>(Specify)</i>	ne, farm, stre	et, factory,			-	8f. Location (S City or Tow		ımber or Rur	al Route Number,
	To the Hospital within 24 hours a To the Funaral C completely filled	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the besinner: On the basis and manner:	or examination	rledge, death on and/or inv	occurred a estigation,	t the time	, date and nion, death	l place, a	nd due to the o d at the time, o	cause(s) and date and plac	manner as s	stated. o the cause(s)
	To t To t	M	29b. Signature and title of certifier	Meps				License	372	287			gned (Month,	-
18	1+0		30. Name and address of person who Stephen Cafferty,				-	7e - 9	Suite	#2	Lughy	Mary	land o	0657
	Sta Registra	te	31. Date filed (Month, Day, Year)		tra Signatu	ıre			urcc	n 4	THURSTY P	ract y.	LUIU Z	0037

			1 - For State Registrar	State of Maryland	/ Departme	ent of Health and ate of Death	Mental Hyg	_	261.71
	Physici /Medic Examin	cal	Decedent's Name (First, Middle, Last) A. Facility Name (If not institution, give:	te Farrell street and number) cpkins Hosp	ital B	y, Town, or Location of Dea	2. Date of Death Month Tuly th	Day Year 19 2003 4c. County of Death Baltimore	2
47	Funeral Director			M 2 → F	Yrs. Month				place (State or Foreign ntry) 1land
	death with the Maryland ms 23c or 28a-f show	ctor	Maryland Calvert		Town or Location Leonard				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	23£ or 2	Funeral Director	10e. Street and Number 5951 Hillside	Road	10f. 2	Zip Code 20685		og. Citizen of What Cou United Stat	
5-0036	4 within 72 hours after death with the Marylan liene. r then "naturel", or Items 23c or 28a-1 show the Madical Extra national count be notified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		cedent of Hispanic Origin? (seeify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White, Specify: Whit	etc.
71212-	filed within 72 h Hygiene. ther then "natu snt, the Wed call	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) n/a	cation e completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of N life. DO NOT n/a	sual Occupation work done during most of wo use retired)	orking	6b. Kind of Business/Ir	ndustry
yland	be de la la la la la la la la la la la la la	To Be	17. Father's Name (First, Middle, Last) unknown				me (First, Middle, N Lynn Far		
e, Mar	nd 2 lith a 27 is		19a. Informant's Name/Relationship (Ty Jessica L. Farrell	- mother	5951 Hill	ss (Street and Number or R side Rd. St.			o Code)
Baitimore			20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	cen	ce of Disposition (A netery, crematory of John Vian	nother place) July 2 ney Cemetery	3 2005	oc. Location - City or To	
Dall	permit Page Department of Importent: If any injury or once.		21. Signature of Europeal Service License	90)	F-10-0-00	and Address of Facility Romes Is. Rd. Po	ausch Funera rt Republic		
	Physician /Medical Examiner	ler	23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to (or as a conseque) Due to (or as a conseque)	istic L	eff Hear	Synd	rome	Approximate Interval Between Onset and Death
68/60,	certificate be executed ording physician and ise as the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	nce of):				
C. BOX	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal di 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 Ectopic			23d. Date of delive Month	ery Day Year
cords, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions cor	tributing to death but not resulti	ng in the underlying	cause given in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to t s 2 No 3 □ Prot	he cause of death? cably 4 Unknown
итат несс	The law ate has b page 2 sl	e Completed	25. Was case referred to medical					ed? prior to co death? No 1 Yes	ppsy findings available impletion of cause of
ō	Phys this ral dii	ToB	examiner?		NOutpatient 3 [Other	ath (Check only one Home 5 Resider 28d. Describe ho	nce 6 Other (Special	ý)
VISION	ottending leath.	ertification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) 28e. Place of Injury - At home	Injury M	Work? 1 ☐ Yes 2 ☐ No		eet and Number or Rura	al Boute Number
2	pitel or urs afte eref Dire	O	4 Homicide determined 29a. Certifier 1 Certifying Phys	building, etc. (Specify)			City or Town,	State)	
	2 2 2 2	Medical	(Check only one) 2 Medical Examination (Check only one) Medical Examination (Check only) 29b. Signature and title of certifier (1)	ner: On the basis of examination and manner stated.	n and/or investigatio	on, in my opinion, death occ	urred at the time, da	te and place, and due to	the cause(s)
	To To		V Waunth A	Imore MD					
		ľ	30. Name and address of person who co	1. tal, 600 h	Wolfe	St Balti	more, M	July 19, a	21287
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2	32. Registra s Signatur	& So	artie	,	1.	

	,		1 - For AMEND#16a, 17, 20 Registrar Per Fh 8/2/	05 AACO HEAL!						nd M	ental Hy	Reg. No. (105	26472
	Physici /Medio		James Eugene	Flemma							Month July	25,	2005	12:05 A ^M
	Examir		4a. Facility Name (If not institution, give	re street and number)			4b. City,	Town, or	Location of	Death			ounty of Death	
			117 Indian Lane					apol		A Llea			ne Arun	
	Funeral Director		5. Social Security Number 6. S 105-30-9065	Magazina Ma	66	last birthday) Yrs.	Months	Days	If Under 24 Hours	Min.	8. Date of Bi (Month, D 05/03	71939	9. Birth Cou New	place (State or Foreign intry) York
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation	-						10d. Inside City Limits
	a-f sh	ctor	Maryland Anne Ar	undel	Anna	apolis								1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number				10f. Zip						n of What Cou	intry?
	e 23a		117 Indian Lane	12. Was Decedent I	Everie II	5 123	214			-0./0	- 1. V N	U.S.A		
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel", or iteme 23s or 28s-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 Xh If Yes, Give Year or Dates:		1	was Dece f Yes, spe 1 ☐ Yes		Spanic Origin, Mexican, I	n / (Spe Puerto f	cify Yes or N Rican, etc.)		. Race - Ameri Black, White pec <i>ify:</i> Wh	, etc.
2-0	72 hor	eted	15. Decedent's E	ducation		16a. Dece	dent's Usu	al Occupa	ition uring most o	of workin	ng.	16b. Kind	of Business/Ir	ndustry
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2	filed Hygi ther int, I		17. Father's Name (First, Middle, Last	4		Presid	ient	I'SA .	18 Mother's	s Namo	(First, Middle	Dire	ct Mai	1 Marketing
lan	should be filed and Mental Hygi s markad other umatic event, I	To Be	Saverio Michael ե	F, Lemma									Ferra	ri
ary		-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street a					own, State, Zij	
Σ	2 4 7 5		Ellen Flemma	(Wife)		117	India	n Laı	ne, An	nap	olis,	MD 214	03	
ore	Pages 1 nent of He int: if iten		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from State	20b. P	lace of Dispo emetery, cren	sition (Name	me of other place	9)	D	ate	20c. Loca	tion - City or T	own, State
ţ	t. Pag tment rent: njury		*4 ☐Donation 5 ☐ Other (Special	(y)	Cal	lvary (/2005			d, MY NY
Bal	permit. Pages 1 and Depertment of Healti Importent: If Item 2: any injury or other t		21. Signature of Funeral Service Ties	~~			LZ KI	ager	y Ave.	Anı	napoli	s, MD	1 Home 21401	P.A.
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rds, P	ires the signed d be de	by	Part II. Other significant conditions of	contributing to death bu	it not resu	ulting in the ur	nderlying o	ause give	n in Part I.		23e. Did 1	,		he cause of death?
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Vital	Physicien: This certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:		ER/Outpatien		Othe	r		(Check only		10.1	
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Division	in Life	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injubuilding, etc	ry - At ho . (Specify	ome, farm, str	eet, factory	y, office		2	8f. Location (City or To		lumber or Rura	al Route Number,
	To the Hospital or within 24 hours after or to the Funerel Directorpletely filled in	ledical	one) 2 Medical Exar	nysician: To the best on niner: On the basis of and manner sta	examinat	wledge, death tion and/or inv	occurred	at the time , in my opi	e, date and pinion, death	place, ai occurre	nd due to the d at the time,	cause(s) an date and pla	d manner as s ace, and due to	tated. o the cause(s)
)	To To corr	W	29b. Signature and title of certifier	nilsa	0			License	183	8		29d. Date s	igned (Month, 27/2	Day, Year)
			30. Name and address of person who STOCUT E.	Selou	Ich	, M		90	0 3	Berj	gak	Au	nuap	olis uni
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Refetra	i s signai	Inte	boods	Es .						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Forney, Sr. Ju₁y 25 2005 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10 Ironstone Court Anne Arundel Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | May 22,1948 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F Director 229-58-0945 57 Virginia Usual Residence of Decedent the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner nust be notified at 1 Yes 2XXNo Directo Annapolis MD Anne Arundel 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 1 ò 23a 10 Ironstone Court 21403 USA death 12. Was Decedent Ever in U.S. Armed Forces? or Iteme 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hyglene. XXYes 2□No HYes, Give Year or Dates: Vietnam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: White 3 ☐ Widowed 4 XX ivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Not Available Hilda M. Forney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Forney (Daughter) 10 Ironstone Court, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 □ Burial 2 X Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 7-27-2005 Metro Crematory Baltimore, MD 21. Signature of Funeral Services Licensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) OC ardia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fulsease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) the attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death Check onl one Pop Other: 4 Nursing Home sidence 6 Other (Specify) 1 ☐ Yes 2 →No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b Time of 28c. injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after deal To the Funeret Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29b. Signature and title of cen 29c. License number 29d. Date signed (Month, Day, Year) 32036 o completed cause of death (Item 23a) (Type, Print) 30 Name and address of p Drine Chita, MD 2

State Registra

31. Date filed (Month, Day, Yar)

32. Rastrar's Signature

			For State	State of Maryland		artment of F		and Me	-	giene Reg. Na.	00=	06171	
			Registrar 1. Decedent's Name (First, Middle, Last	·)		incate or	Dealin		2. Date of Dea	ath	000	3. Time of Death	_
	Physici		SAMUEL FRENCH FOLI	ZC CR					Month July	25	2005		М
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location o	of Death	July		County of De		_
			Prince George's Ho	nsnital		Cheverl	v			Pr	ince (George's	
	Funeral		Social Security Number 6. Se	x 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Da	h		Sirthplace (State or Foreit Country)	gn
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	pu *		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	cation						10d. Inside City Limit	+0
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	the M	Director	MD Prince Go	eorge's Tux	edo	10f. Zip Code				10= Chi-			_
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10	fter d	F	1 Never Married 2 Married	Armed Forces?	41-	Was Decedent of H f Yes, specify Cuba	n, Mexican	, Puerto R	ican, etc.)	'	Black, Wh		
33	urs a	by	3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No 194 If Yes, Give Year or Dates: 19		I□Yes 2∏No	Specify:				Specify:	Thite	
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Maryland 21215-0036	tal Hydral Hydral	Be	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle,	Maiden S	Sumame)		
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<u>~</u>	and lealth m 27 her ti		Theola D. Folks,			57th Pla	ce, T				2078		
0	ges 1 t of h If its or ot		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F	1 00	metery, cren	sition (Name of natory or other plac		Da		20c. Loc	ation - City o	or Town, State	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-1 show appring to other traumatic event, the Medical Examinat must be notified at an once.		21. Signature of Funeral Service Licens	9	1	. Name and Addres							
	TO 2 4 Q		fallet !	1/ac							ille,	Maryland	
			23a. Part1 Enter the disease, or complishock or heart failure. List only o	ne cause or each line.	Do not ent	er the mode of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death	
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ord	w require been si should t	ed							101	′es 2□	No 3□	Probably 4 X Unknow	'n
900	e law re has be je 2 sh	Completed							24a. Was		24b. Were	autopsy findings availab completion of cause of	le
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<u>~</u>	hysic nis ce I dire	To	1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 🖔 E	R/Outpatien	t 3 DOA Oth	er: 4□ Nui	rsing Hom	e 5 Resid	lence 6	□Other (Sp	necify)	
0	Attending Physicien: r death. sctor: After this certifice by the funeral director, I		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor	/ at		3d. Describe h				
Sio	lendi eath. or: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 1	No					
Division of Vital Records,	or Attendent efter deatl	Certification;	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	eet, factory, office		28	3f. Location (S City or Tow		Number or i	Rural Route Number,	
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	T 4 H G	Medicai	29a. Certifier 1 ☑ Certifying Phy (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	rledge, death on and/or inv	occurred at the time restigation, in my o	ne, date and pinion, deat	d place, ar th occurred	nd due to the d d at the time, d	cause(s) a date and p	nd manner : lace, and di	as stated. ue to the cause(s)	
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)	F \$ F 8		& S. Den	west Mo)	70	0155	778		T., 1,,	26	2005	
1	2111		30. Name and address of person who co	ompleted cause of death (Item	23a) (Tyne			- 0		July	26,	2005	
+	Va		Sukumaran C. Arya			rry Stree	et. Mo	ount 1	Rainie	c, Ma	rylan	d 20712	
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state 729-05 Registranmend #16a.PerFH #31.PerVR PCC Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician IARG-AR 7-1:35 M 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSP174 E Rockville Lout Gomero If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State of Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 □ M 2 1 F 517-01-5600 Knoxville, Yrs. Director 10/2 Usual Residence of Decedent 10a. State MD 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at Montgomery Rockville Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 625 West Lynfield Drive 20850 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 24 ☐ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dental Assistant Seculary Dentistry 12 i. Peges 1 and 2 should be filed w tment of Health and Mental Hygle tant: if Item 27 is marked other ti jury or other traumatic event, III other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hugh M. Parker Rosalee George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Fraysier (SON) 18140 Rolling Meadow Way Olney, MD 20832 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 7/29/2005 permit. Peg Department Important: i any injury o Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Fun, ral Serv of Licensee \$401 Bladensburg Road Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiclen and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2No 3 Probably 4 Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performed' 2**X** No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending s after decrei Attender Attend 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide thin 24 hours a VC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. within 7 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 ZULIMA COURT Hakim MORSLI

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signat

Gleen & Sparle

		1_ For State	State of Maryl	and / Depa		aith and Me	ental Hygie	2005	261.77
		Registrar		Ce.	runcate of De		Reg. 2. Date of Death	NGL U U U	204//
Physic	ian	Decedent's Name (First, Middle, La	sr)				Month	Day Year	3. Time of Death
/Med		Stephanie		Fi	nkbeiner		July 25	,	6:00 P ^M
Exami	ner	4a. Facility Name (If not institution, giv			4b. City, Town, or Lo	cation of Death		4c. County of Dea	ın
		William Hill Mano 5. Social Security Number 6.8		ter yrs. last birthday)	Easton	f Under 24 Hrs.	B. Date of Birth	Talbot	thplace (State or Foreign
Funeral Director			□M 2€F	Yrs. iasi biririday) Yrs.		Hours Min.	(Month, Day, Yo	ear) Co	ountry)
		207-14-5431 Usual Residence of Decedent	^ 79				une 16,1	926. ⊥ Pe	nnsylvania
/land		10a. State 10b. County	10c.	. City, Town or Lo	ocation				10d. Inside City Limits
Man Man	tor	Maryland Dorches	ter	Churc	h Creek				1 □ Yes 2√DMO
) # L	Funeral Director	10e. Street and Number			10f. Zip Code	-	10g	. Citizen of What Co	ountry?
23a (a D	1932-2 Church Cr	eek Road		21622			US	
deat	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban,	anic Origin? (Spec	ify Yes or No-	14. Race - Ame Black, Whit	erican Indian,
after of the land	臣	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 No			Specify:	ican, etc.)		
Sours ours	db	3 Widowed 4 □ Divorced	Year or Dates:		1 □ Yes 2√ No S			Specify:	White
72 h	Completed	15. Decedent's E (Specify only highest gra		(Give	dent's Usual Occupation kind of work done duri	on ing most al working	16	b. Kind of Business	/industry
ithin ne.	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)			_	
led v tygie ther t		12 17. Father's Name (First, Middle, Last	1	H	omemaker	3. Mother's Name ((Cirot Adiabata Ada	Own H	ome
be fi	Be				,,,				
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural", or Items 23a or 28e-1 show aumatic event, the Medical Examiner must be notified at	မ	Steven Krzystos		405-14-35			ankiewic		7.0.71
VICAL 12 st h and 7 ls n traun		19a. Informant's Name/Relationship (ng Address (Street and			2000 90 8800	
partition by Mary ylation 2.12.13.0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Importent: If Item 27 is marked other then "netural", or Items 23a or 28e-1 show eny injury or other traumatic event, the Madical Examiner must be notified at once.		Kathleen Smith D 20a. Method of Disposition	aughter	b. Place of Dispo	4 Brooks R	oad Woolf Da	tord, Mai	cyland 21 c. Location - City or	577 Town State
Pages nent of l		1 Burial 2 Cremation 3	Removal from State	cemetery, cre	matory or other place)	-			
it P.		*4 □ Donation *5 □ Other (Special 21. Signature of Funeral Service Lice			y Cremator Name and Address of		705 Sa	alisbury,	Maryland
permit. Departr Importe eny inji		21. Signaturi di Funeral Seprice Lice	1500	T	homas Fune:	ral Home.	P.A.		
		23a. Part . Enter the disease, or com	plications that caused the	7	00 Locust :	Street Ca	mbridge,	, Marylan	d 21613 Approximate
		shock, or heart failure. List only	one cause on each line.	-/ /	1 1				Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Ineta	state	c lune	car	cenor	ng	6 mo
Examiner			Due to (or as a con	sequence of):	()			
	ē	Sequentially list conditions, if any, leading to immediate	b. — Eus to (or as a con	sequence of)					
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be executed sicien and burial-transit	Exa	resulting in death) Last	Due to (or as a con	sequence of):					
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iffical g phy as th	Physician/Medic							T	
h cer endin	N/Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy			23d. Date of de	
deat death ed for	sicia	in the past 12 months?	4□Pregnant at time 9□Unknown		Other (specify)			Month	Day Year
by the	hys	9 ☐ Unknown ⁽	9LI OHKHOWH						
esth:	by F	Part II. Other significant conditions	<i>J</i>	_		in Part I.			the cause of death?
aquir en si		resiracio	e lung d	mas			1 20 Yes	2 □ No 3 □ Pi	robably 4 Unknown
as be	Completed	Chronie of	structu	e pul	monary	descase	24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
The The ate h	moX				J		performed 1 ☐ Yes 2 5	d? death?	·
sen:	Be (25. Was case referred to medical examiner?			2	6. Place of Death ((Check only one)		
Physic this co	2	1 ☐ Yes 2 XNo	Hospital: 1 Inpatient	2 ER/Outpatie			e 5 🗆 Residenc	e 6 □Other (Spe	cify)
ing P Witer t	on:	27. Mapner of Death 1 DNatural 5 □ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o	Work?		3d. Describe how	injury occurred	
tendi leath. for: A	catl	2 Accident investigation 3 Suicide 6 Could not be				s 2 □ No			
or At fiter d	Certification:	4 Homicide determined		At home, farm, st pecify)	reet, factory, office	28	31. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
urs a		00.0.4%	The board of	lean le de colonia					
To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Examone)	nysician: To the best of my niner: On the basis of exam and manner stated.	nination and/or in	n occurred at the time, vestigation, in my opini	date and place, ar ion, death occurred	id due to the caus d at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
thin the	Mec	29b. Signature and little of certifier	1011 mariner stated.		29c. License n	umber	29d.	. Date signed (Mont	h, Day, Year)
F 3 F 8		Dh Chan	Whe m	D	カ	3528	4 .	7/20/08	
		30. Name and address of person who	completed cause of docth	Item 23a\ /Time	Print)			11-06-00	*
		AMONSA A	LIDW MI	719 19	Print) Print) Anach	wotons	+ Ba	Ston MI	021601
		1111-01	/ILI/	4//	J. Vicero	- 1		, . , .	
Si	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature		0			

DHMH 17 Rev 1/2001

Registrar

Greenway

			For Stete Registrer	State of I	Maryland / Dep <i>Ce</i>	artment of ertificate of			iene	261.79
	Physici	ian	Decedent's Name (First, Middle	e, Last)				2. Date of Deat Month		3. Time of Death
	/Medi		Andrew	Ε.		Greene		Ju1y	22 2005	3:30 p ^M
100	Examir	ner	4a. Facility Name (If not institution	. 0	er)		or Location of Death	1	4c. County of Dea	
\$00g	Fundanal		100 Kent Road 5. Social Security Number		Age (In yrs. last birthday		nsville	8. Date of Birth	Queen Ar	
	Funeral Director		225-31-3515 Usual Residence of Decedent	1 XX M 2□ F	33 Yrs.	Months Days		Jan. 3,	1972 Vi	thplace (State or Foreign cuntry) rginia
	nyland show	L	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	he Ma 28a-f s	Director		Annes	Steven					1 ☐ Yes 2 📉 No
	with the or 3		10e. Street and Number 100 Kent Road			10f. Zip Code	1666	11	0g. Citizen of What Co	ountry?
	ns 23	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S. 13.		21666 Hispanic Origin? (Si	pecify Yes or No-	USA 14. Race - Ame	arican Indian
330	172 hours after death with the Maryland "natural", or items 23c or 28a-f show calcal Exarciting Project Collised at	by Fun	1 ☐ Never Married 2 Marriad 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1XX es 2[s? □ No	If Yes, specify Cul 1 ☐ Yes 2X No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	
Š	72 hou nature	ted	15. Deceden (Specify only highe:	t's Education	16a. Dece	dent's Usual Occu	ipation a during most of work	king	16b. Kind of Business	/Industry
12	~ * 3	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)	DO NOT use retir	ed)	\"ig	xx 1.	
7	filed withir Hygiene. other than		17. Father's Name (First, Middle,	Last)	Sales	3	18 Mother's Nam	ne (First, Middle, N	Yacht	
Baltimore, Maryland 21215-0036		To Be	Joseph S. Gree					e Terpst		
ary	and and s m	Γ.	19a. Informant's Name/Relations	hip (Type, Print)	19b. Mail	ing Address (Stree	1		City or Town, State, 2	Zip Code)
≥ ຜົ	C = 04 F		Nancy Greene (Wife)			d, Steven	-		
פֿב	S = 0		20a. Method of Disposition 1 Burial 2 Cremation				1		20c. Location - City or	
			* 4 □ Donation 5 □ Other (S		Metro Cre	ematory 2. Name and Addr	-	/2005	Baltimore,	MD
ñ	permit. Departr Importa any inji		23a. Part1. Enter the disease, or shock, or heart failure. List	X-		Hardesty 12 Ridge	Funeral 1y Avenue	, Annapo	lis, MD 21	401
,0070	Medical Examiner of the burial-transit	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	as a consequence of): as a consequence of): as a consequence of):	Kidne	y Cano	en		Onset and Death 23 m on T
O. DOX o	the death certify the attending iched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3(at time of death 5(□Ectopic pregnand □ Other (specify) _	Dy .		23d. Date of del Month	ivery Day Year
us, r	es tha igned be de	by	Part II. Other significant condition	ens contributing to death	n but not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did toba	acco use contribute to	
II Kecords,	The law ate has b page 2 st	Completed						24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
VItal	Physician: This certificaral director, p	Be	25. Was case referred to medical examiner?	Hospital:				h (Check only one)	
5	ding Phys h. After this funeral di	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date of Ir (Month, L	njury 28b. Time o	f 28c. Inju	-	ome 5 Resider 28d. Describe how	nce 6 □Other (Spec w injury occurred	city)
DIVISION	I or Attending after death. Director: After	Certification;	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determine	not be	Injury - At home, farm, st etc. (Specify)			28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To tha Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fo	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medicel I	g Physicien: To the bes Exeminer: On the basis and manner	st of my knowledge, deat of examination and/or in stated.	h occurred at the ti vestigation, in my	ime, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To tha h within 24 To the 8 complete	Me	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Month	, Day, Year)
			+ occurren	Lot M	\mathcal{G} .	Doc	1870	- 6	7-26	-05
			30. Name and address of person of Richard W.	who completed cause of	death (Item 23a) (Type,	Print)				
×	Sta Registr		31. Date filed (Month, Day, Year) JUL 2	8 2005 32. R	strar's Signature					

State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 28, July 2005 9:15 A Hutchison Ronald Everett /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Calvert Memorial Hospital Calvert Prince Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Say 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**∑**M 2□ F Yrs. 4, 55 Jan. 1950 Maryland Director 217-58-1449 Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "netural", or Items 23a or 28a-f show the Medicul Eva ther must be notified at 1 X Yes 2 No Chesapeake Beach MD Calvert Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20732 U.S.A. 3914 13th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) carpet and furnishing V.P. hotels 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) it. Pages 1 and 2 should be satment of Health and Mental ortent: If item 27 is marked o Frances Irene Windsor Thomas Hutchison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 2714 Garrity Rd., St. Leonard, MD 20685 Linda L. Gollehan, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) njury or So. Memorial Gardens 08/01/2005 Dunkirk, MD 21. Signature of Funeral Service Ligensee permit.
Departr
Importe
any ni 22. Name and Address of Facility elecul Rausch Funeral Home, P.A., Owings, MD 20736 yen 23a. Part 1. Enter the r isease, or commercations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) several much Physician Itiple 5 to Kes /Medical Due to (or as a consequence of): Examiner netostatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due lo (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed D1010 Due to (or as a consequen - of) Division of Vital Records, P.O. Box 68760. Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate 2 N 1 Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending 1 Yes 2 No investigation 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide the Hospitel 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 28 0 60390 HOSP ITALIST, mg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSP ITAL RINCE 100 JABER 32. Registrar's Sig State

DHMH 17 Rev 1/2001

Registrar

Registrar
DHMH 17 Rev 1/2001

Clarence Perry Ingram Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-05051 State of Maryland / Department of Health and Mental Hygiene NJM Reg. No. UU5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 24 2005 2145 July Clarence Perry Ingram /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Laurel Regional Hospital If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) Birthptace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 XM 2 ☐ F Sep. 1926 Virginia Director 78 10, 228-24-5363 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland | Prince George's Laurel 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 7901 Laurel Lakes Court Apt.# 115 20707 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Tes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8 Press Operator Printing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi Manie Estelle Dix Homer Lee Ingram 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Depertment of Health and important: If Item 27 is m any injury or other traum Marjorie Holland / Sister 2548 Rutland Road, Davidsonville, MD 21035 July 29, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 2005 Crematory, Inc. 22. Name and Address of Facility Veterans Funeral Care 21. Signature of Funeral Service Licensee M00956 15381 Roosevelt Blvd., Clearwater, FL 33760 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 14 to xication **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner for use as the burial-translt that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 hes Yes 2 No VZ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 XER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Subject ingested exti-freeze efter death. Director: Af Found 7/23/05 Found 6:30 M investigation 2 Accident Location (Street and Number or Rural Route Number City or Town, State) 7-201 Laurel (a 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Car Court #115, Caurel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **OCME** July, 27, 2005 who completed cause of death (Item 23a) (Type, Print) 146 111 Penn Street, Baltimore, MD 21201 Registrar's Signature 31. Date filed (Month State Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		artment of H		•	giene	105	261.93
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5-0036	within 72 hours after death with the Maryland ena. than "natural", or Items 23s or 28a-1 show Is Modical Ext., direct, and be notified at	ed by	3 Widowed 4 ☐ Divorced 15. Decedent's Edu	If Yes, Give Year or Dates: 4/4/-		1 ☐ Yes 2 No dent's Usual Occup	Specify:	-		Specify: Blood of Business/Inc	
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	To th within To th compl	Me	29b. Signature and title of certifier	MO (OME) (01	m2.)	29c. License	number			signed (Month,	Day, Year)
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			Registrar 1. Decedent's Name (First, Middle, Last)		Reg. i	Ng. UU J J J J J J J J J J J J J J J J J J	
и	Physici		Mary Natalie Jackson	Jul		2005 Year 7:00 A	4
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	_
			13144 Sankston Place	Newburg		Charles	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	ay) If Under 1 Year If Under 24 Hrs. 8. Dat	e of Birth	9. Birthplace (State or Foreign	n
	Director		220-92-6113 1 N 2 T 78 Yrs	Months Days Hours Min. (Mo Novemb	er 3.	1926 Maryland	
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Maryland	ges 1 and 2 should to f Health and Mer if itam 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print) Susan Jackson Brown/Daughter	illing Address (Street and Number or Rural Route	Number, City	y or Town, State, Zip Code)	
_	1 and Healt am 2 thar			sposition (Name of Date		Location - City or Town, State	_
Baltimore	permit. Pages 1 av Department of Hea Important: If itam any injury or otha once.		1 X Burial 2 Cremation 3 Removal from State	rematory or other place)			
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	o the	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)	
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(-	30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print), (1	_
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IOCE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. It of Health and Mental Hygiene. Or of the marked other than "natural", or Items 23a or 28a-f show or other traumatte went. The Medical Familie or nother traumatte in the fired or the property.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	16a. Decedent's L (Give kind of life. DO NO Secret	work done during m Tuse retired)	ost of working	16b. Kind of Busines	ss/Industry
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Battimore, Mapermit. Pages 1 and 2 st Department of Health ar Important: If tiem 27 is any injury or other traus.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe	Removal from State	Place of Disposition (cometery, crematory)	Name of or other place)	August 3,	20c. Location - City Calvert, M	or Town, State
Baltimo permit. Page Department of Important: If any injury or	once.	21. Signal re of Funeral Service Li	sensee S. Heehs	Hicks 103 W	and Address of Fa Home for Stockto	Funerals, on Street, E	P.A. 1kton, Mary	land 21921
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		30. Name and address of person with Farks 1	o completed cause of death (Iter	n 23a) (Type, Print) W-NL	in Che.	saprolle H	ospice Eli	KTon MD
		,31. Date filed (Month, Day, Year)	32. Registrar's Signa					

Physici /Medic		neglistrar Amend #19a.Per DoroTHY KEAR	NEY				Date of Death Month 07		2003	3. Time of Beat 0 1 : 46
Examir	er	4a. Facility Name (If not institution, give CASEY HOUSE/ MC	street and number) NTGOMERY HOSE	PIŒ RÔC	ty, Town, or Location KVILLE	n of Death		MONT	y of Death GOMER	Y
Funeral Director		5. Social Security Number 579-62-9307 6. Se Usual Residence of Decedent	7. Age (In yrs. las	st birthday) If Uni Month		er 24 Hrs. 8. Min. 0 1	Date of Birth (Monte Day)	924	Country	ce (State or Fore () NTA GA
a-f show	ctor	10a. State DC 10b. County DC	10c. City,	Town or Location WASH	INGTON				10d	. Inside City Lim
3s or 28	al Dire	10e. Street and Number 5103 13TH N.W.		10f.	Zip Code 20011		10- T	g. Citizen of J.S.A	What Country •	1?
Department of Heath and Mental Hygiene. Important: If item 27s or 28s-1 show any injury or other traumatic event, the Medical Exemples must be mutified at 200s.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		cedent of Hispanic (pecify Cuban, Mexic		Yes or No- an, etc.)		ce - American ick, White, etc fy: BL	
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aith and Men 27 is marke r traumatic	ပို	19a. Informant's Name/Relationship (T) BARBARA TOLLE	rpe, Print) SCOV sister	19b. Mailing Addre	ess (Street and Num ACEFIELD	nber or Rural R	oute Number,	City or Town	, State, Zip Co SPRIN	_{оде)} 20904 G , MD
nont of Health nt: If itam 27 ry or other tr		20a. Method of Disposition **Burial 2 □ Cremation 3 □ f * 4 □ Donation 5 □ Other (Specify,	20b. Pla Removal from State MARY	ce of Disposition (f	Vame of AL EMETERY	07-29-20			- City or Town	
Department of I Important: If its any injury or o		21. Signature of Funeral Service Licens	mille	^{22. Name} 3015 12	and Address of Fac IH SIREET N	E. WASHI	RHINES NGION, D	FUNERA C 20017	L HME	
rysician		23a. Parf. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. ne cause on each line. aPAVREAPIC OA		node of dying, such a	as cardiac or re	spiratory arres	st,	tr.	pproximate iterval Between inset and Death
Medical xaminer			Due to (or as a conseque							
physician and s the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Chief to that initiated events resulting in death) Last	Due to (or as a conseque Due to (or as a conseque							
y the attending physician and tched for use as the burial-transit	Medical	IF FEMALE:	.t.					1		
ed by the attending physidetached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 XNo 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3 Ectopic	pregnancy (specify)			1	ate of delivery onth Da	ay Year
.5. B	by	Part II. Other significant conditions co	ntributing to death but not result	ing in the underlyin	g cause given in Pai	t I.	23e. Did toba			cause of death?
ate has been s page 2 should	Completed						24a. Was an autopsy performe	Į.		y findings availal letion of cause of
is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	lospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient 3□	A Committee of the Comm	ce of Death (C			ner (Snecify)	OSPICE
h. After th funeral		27. Manner of Death 1XX Natural 5 Pending 2 Accident investigation		8b. Time of Injury	28c. Injury at Work?	28d	. Describe how			
within 24 hours after deatl To the Funaral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, fact	ory, office	28f.	Location (Stre City or Town,	et and Numi State)	ber or Rural R	loute Number,
n 24 hours afte a Funaral Dir letely filled in	edical	29a. Certifier (Check only one)	sician: To the best of my knowl ner: On the basis of examinatio and manner stated.	edge, death occurr in and/or investigati	ed at the time, date ion, in my opinion, d	and place, and eath occurred a	due to the cau at the time, dat	se(s) and m e and place,	anner as state and due to th	ed. le cause(s)
within 2. To tha 3. complet	Me	29b. Signature and title of dertifier	~ ~	>	29c. License numbe D 35635	r		d. Date signe	ed (Month, Da 2005	y, Year)
1)		30. Name and address of person who c	ompleted cause of death (Item 2	(Type, Print)						

05	054		Please 1				Indelible Ink		•		-	
)			For State	State of Ma	arylar		epartment of I Dertificate of		nd Mental H	_	~ ~ ~	00107
1 %		,i	1. Decedent's Name (First, Middle, Last)				ertificate of	Death	2. Date of D	Reg. N	KUU5	3. Time of Death
3	Physic /Medi			right_	- 1	Line	han		July 2	D.	ay Year 2005	2226 P M
	Examir		4a. Facility Name (If not institution, give :			91110	4b. City, Town, o	or Location of			c. County of Dea	
	, w.		Route 4 @ Mount Ha				Owings				Calvert	
W.	Funeral Director		5. Social Security Number 6. Sec. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	M 2X F		last birtho	Months Days		Min. 8. Date of B (Month, D	lay, Year	r) Co	thplace (State or Foreign
	D		Usual Residence of Decedent		88				Dec_11	, 12	916 Vir	ginia
	ahow ahow	ž	10a. State 10b. County		10c. Cit	ty, Town o	r Location					10d. Inside City Limits
	the N	Director	MD Calve	ert			Owings 10f. Zip Code			10a C	hitimon of Miles C	1 Yes 2 No
	d within 72 hours after death with the Maryland jiene. I'r than "natural", or Itams 23a or 28a-1 ahow the Madical Exarta art i ust be indiffed at	Di	9109 Hall Court					20736		10g. C	Citizen of What Co USA	ountry?
	ams 2	Funeral		12. Was Decedent Armed Forces?	Ever in U	.S.	13. Was Decedent of I If Yes, specify Cub		n? (Specify Yes or N	0-	14. Race - Ame	
36	s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 📉 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N	No		1 ☐ Yes 2X No		dento i lican, etc.)		Black, White Specify:	
8	hour tural	ed b	15. Decedent's Educ	Year or Dates:		16a D	ecedent's Usual Occup	nation		165	Kind of Business	
215	within 72 ene. than "nat	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	(+)	10	ive kind of work done e. DO NOT use retire	during most o	f working	100.1	Kind of business	moustry
2	fited within Hygiene. other than	Соп		4	.,	ele	ementary so			-	blic sc	hool
Maryland 21215-0036	d be find the nate of the other orthogonals avairable to the other controls avairable to the o	Be	17. Father's Name (First, Middle, Last)	T.7	المالية				Name (First, Middle			
Ž	should od Me mark matic	ဥ	Garland 19a. Informant's Name/Relationship (Type		ight	19b M	ailing Address (Street	Lilly			Flemin	9 Zip Code) 22304
	alth all		Hubert T. Linehan				00 Holmes F					
Baltimore,	of He of He filtam r othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	amount from State	20b. P	face of Di	sposition (Name of crematory or other place		Date		ocation - City or	
Ë	Pag tment tant: I		4 Donation 5 Other (Specify)	emoval nom State	Res	surre	ction Ceme	etery 0	8-01-05	Cli	inton, M	D
Bai	permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if Itam 27 is marked other t any injury or other traumatic avant. In once.		21. Signature of Euperal Service License				22. Name and Addre	,				
w All	5.00		23a. Part1. Enter the disease, or compliance of the compliance of	cations that caused	the death	n. Do not	Rausch Fur	neral H	ome, P.A.	, Ow	vings, M	D 20736 Approximate
4	Physician		Immediate Cause (Final	e cause on each in	ю.		i'u punés					Interval Between Onset and Death
	_/Medical		disease or condition resulting in death)	Due to (or as	a consequ	uence of):						
	Examiner	L	Sequentially list conditions, b									
	ted nsit	Examiner	many, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as t	t consequ	ualica of).						
ć	s be executed sician and burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a	a consequ	uence of):						
3760,	ate be hysicia he bui	icai	d									
x 687	death certificate be a stending physic	Med	IF FEMALE:									
Вох	attend for us	cian	in the past 12 months?	ic. If yes, outcome of the first term of the fir	2 🗌 Fetal	death	3 □Ectopic pregnancy 5 □ Other (specify) _	,			23d. Date of del Month	very Day Year
P.O.	0 0 0	by Physician/Medic	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown								
	igned be de	by P	Part II. Other significant conditions conf	ributing to death bu	it not resu	alting in th	e underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ord	w requir been s should	eted							_ 10	Yes 2	Mo 3□Pr	obably 4 Unknown
Vital Records,	to a c	Completed							- 24a. Was			topsy findings available completion of cause of
ta		O	25. Was case referred to medical			79		00 Diago -	1 ∫ ⊈Yes	2 □ No		2 No
	Physicia this cert al direct	To B	examiner?	ospital:	nt 2 🗆 I	ER/Outpa	tient 3 DOA Oth	0.00	Death Check only		6 XiOther (Spec	at scene
0	Ing Pt		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year)	28b. Timi Injur			28d. Describe	how inju	iry occurred	
Division of	*Attending Physician: or deeth. ector: After this certific by the funeral director.	ertification;	Accident investigation 3 Suicide 6 Could not be	7/26/65		4 in len		Yes 25 No			well by	
<u>≥</u>		ertif	4 Homicide determined	building, etc	. (Specify	(fre	street, factory, office		City or To	wn, State	nd Number or Ru e) Urmthy (U	ral Route Number,
	Hospital or Attendin 24 hours after death. Funeral Director: Aft tely filled in by the fur	caic	29a. Certifier (Check only 2XMedical Examin.	cian: To the best o	f my knov	wledge, de	eath occurred at the tin	ne, date and p	lace, and due to the	causals) and manner ac	stated
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	one)	and manner stat	examinat	ion and/oi	investigation, in my of	pinion, death o	occurred at the time,	date and	d place, and due	to the cause(s)
	5 1 × 5 0		29b. Signature and title of certifier	se			29c. License				tte signed (Monti	, ,
		-	30. Name and address of person who con	npleted sause of de	ath (Item	23a) /Tvr	O.C.1	1. E.		Jul	y 27, 20	JUS
_	10		ZABILLEAM	14			enn Street,	Balti	more, Mar	ylan	d 21201	
1	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signat	ure			-			

State Registrar

Bloom & Sparks

			1 - For State Registrar	State of Ma	aryland / Dep	artment o				iene a. N2 N N	E 26100
			Decedent's Name (First, Middle, La	st)		rimouto	01 200		2. Date of Death		3. Time of Death
	Physici		Margaret	Julia	Lea	rv			Month Ju1v	23 200	Year
	/Medi Examir		4a. Facility Name (If not institution, giv		Dea	_	wn, or Location	ion of Death	July	4c. County	
			Genesis - Severn	a Park		Sever	na Par	rk		Anne	Arunde1
	Funeral		Social Security Number 6. S		e (In yrs. last birthday	If Under 1 Y Months D		der 24 Hrs.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		1/3-12-4904	□ M 2 🟋 F	85 Yrs.	Months	ays Hour	rs Min.	Jan. 30	,1920	Pennsylvania
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	nontine					
	show	ō									10d. Inside City Limits 1 ☐ Yes 2√XNo
	the A	Director	MD Anne Ar	undel	Severna						3.5
	hours after death with the Maryland turel', or Items 23a or 28a-f show all Examiner must be multised at	급				10f. Zip Co			10	g. Citizen of W	/hat Country?
	eath	Funeral	53 St. Andrews F	12. Was Decedent I	Ever in II S 12	Mas Dosedont	2114		aif. Van as Na	USA	A
10	fter d	L'H	1 Never Married 2 Married	Armed Forces?		If Yes, specify	Cuban, Mexi	ican, Puerto P	cify Yes or No- Rican, etc.)		k, White, etc.
936	urs a	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢	No Spec	cify:		Specify:	White
21215-0036	"naturel",	Completed	15. Decedent's Ed	lucation	16a. Dece	dent's Usual O	ccupation		1	6b. Kind of Bu	siness/Industry
21	within 7 ene. then "r	ed.	(Specify only highest gra	College (1-4or 5	life	kind of work d DO NOT use re	one <i>durin</i> g m e <i>tired)</i>	no <i>st of workin</i>	g		
21		Son	12		Home	naker				Own H	Iome
pu	be filed ntal Hygi sd other event, I	Be (17. Father's Name (First, Middle, Last)				18. Mo	other's Name	(First, Middle, M	aiden Sumame	a)
yla	should be nd Mental marked c	2	Joseph Vincent V	estrocy			E1	izabet	h Sabo		
Maryland	C (G 00 0		19a. Informant's Name/Relationship (ng Address (St	reet and Nun	mber or Rural	Route Number,	City or Town, S	State, Zip Code)
	and sealth m 27		Patricia L. Cart	er (Daught		St. And:	rews R		everna :	Park, M	D 21146
Baltimore,	Pages 1 ar		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disponentery, cre	sition (Name of matory or other	of place)	Da	ate 2	0c. Location - (City or Town, State
Ë	permit. Pages Department of Importent: If i any injury or once.		' 4 □ Donation 5 □ Other (Specific		Arlington	Nat.	Cem.	08-17	-2005	Arlingt	on, VA
Sall	permit Depar Impor Impor any in		21. Signature of Funeral Service Vices	•	2	2. Name and Ad	ddress of Fa	cility	Home, P		
	g O E € 0		12-4.U	gr-		_12 Ric	dgely	Avenue	. Annapo	olis. M	D_21401
П			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not en	er the mode of	dying, such	as cardiac or	respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, gast	vointe	っかへ	oll	be o	e dit	f	Onset and Death
	/Medical Examiner		resulting in death)	Due o (or as a	consequence of):	1		1		V)	
		_	Sequentially list conditions, if any, leading to immediate	b. ———	unde	Herm	inec	2 e	50/07	gn.	
Т	ed	Examiner	rt any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					0	
_	cate be executed physician and the burial-transit	xan	that initiated events resulting in death) Last	c	consequence of):						
8760,	be e ician buria	a E									
387		dlcal		d							
×	death certifi e attending id for use as	Physiclan/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy					201.0	
Вох	that the death cer ed by the attendir detached for use	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at 1	2 ☐ Fetal death 3 ☐	Ectopic pregna Other (specify				23d. Date Mont	of delivery th Day Year
o.	0 0	ıysi	1 Urknown	9□ Unknown		2 Other (Specify	·/				
<u>α</u>	The taw requires that the tee has been signed by thoage 2 should be detached.	y P	Part II. Other significant conditions co	entributing to death bu	t not resulting in the u	nderlying cause	given in Pai	rt I.	23e. Did toba	cco use contrit	oute to the cause of death?
rds,	quires n sign	d by	anemia, ac	lvance	1 den	ren?	Na		1 ☐ Yes	2 No 3	B ☐ Probably 4 ☐Unknown
00	w requir been si should	lete							24a. Was an	24b W	ore autopey findings available
Record	The tay	Completed							autopsy	pr	ere autopsy findings available ior to completion of cause of eath?
Vital		a	25. Was case referred to medical						performe 1 Yes 2		☐Yes 2☐No
	S :=	0 8	examiner?	Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Outpatier	t 3 DOA	Other .		Check only one)		
o	ding Phy h. After thi funeral c	\vdash	27. Manner of eath	28a. Date of Injury	28b. Time o	28c. l	niury at		e 5 Resident		
ion	ttending I death. stor: After the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury		Work? 1 □ Yes 2 [□No			
Division	or Attendater death Director: in by the	ertiflcation;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injul	ry · At home, farm, str	eet, factory, offi	ce	28	f. Location (Stre	et and Number	or Rural Route Number,
	s after st Direction by	Cert	Tomorda	building, etc.	(Specify)				City or Town,	State)	
	Hospitel 24 hours Funerel etely filled	al	29a. Certifier Certifying Phy	sician: To the best of	my knowledge, deatl	occurred at the	e time, date	and place, an	d due to the cau	se(s) and man	ner as stated.
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	ledical	(Check only one) Medical Exem	iner: On the basis of and manner stat	examination and/or in	restigation, in m	ny opinion, d	eath occurred	at the time, date	and place, an	nd due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	ree,	2	29c. Lic	ense numbe	5 , 1, 0	29d	. Date signed	(Month, Day, Year)
			10	2				D414	53	7-21	.05
	-		Name and address of person who o	ompleted cause of de	ath (Item 23a) (Type,	Print)			11100	10001	le 1110
			Ceserca Elor	1MV 860	1 vexera	nchi	show	en,	Mill	2110	0
	Stat		31. Date filed (Month, Day, Year)	005 32. Fistrai	's Signature	Smeth of		1			0
	Registra	ar I	AAF - 4 .		- 40 B						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra/MEND#18,20b/operFH8/1/05,EMV,McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Ann W. Lattimore 12:01 PM Ju₁y 23. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hospital Suburban Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F Yrs. Director 219-38-0229 66 June 25, 1939 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10220 Holly Hill Place 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours atter onent of Health and Mental Hygiene. ant: if Item 27 is marked other than "natural", or Ital 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Political Aide State of Maryland 18. Mother's Name (First, Middle, Maiden Sumame)
Vera Hill 17. Father's Name (First, Middle, Last) is marked of Robert Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health i Vera Lattimore Rowe/ daughter 10220 Holly Hill Pl., Potomac, MD other 20b. Place of Disposition (Name of Unix cemetery, crematory or other place) 20a. Method of Disposition Date 120c. Location - City or Town, State Unit 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If any infury or once. ¹ 4 □ Donation 5 □ Other (Specify) Gate of Heaven 8-6-05 Silver Spring, MD 22. Name and Address of FacilityMcGuire Funeral Service 21. Signature of Funeral Service Lican ee 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** COPD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Tobacco Abuse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial 0 / PM Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Y Yes 2 No 3 Probably 4 Unknown Melena Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2**K** No this certificate 2 □ No 1 🗌 Yes 1 TYes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Manpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ XVo Certification; To sion of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1X Natural 5 Pending 1 Yes 2 No investigation 2 Accident Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours at To the Funeral D completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Steven Wilks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

29

4700 Morgan Drive

32. Registrar's Signature

the

0

Enter

Chery Chase MD 20815

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Mary		artment of rtificate of		Mental Hygi	g. No 2005	26490	
	Dharaisi	П	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year	3. Time of Death	
	Physicia /Medic		Doris	Dulin	La	rmore			26 2005	6:10a. м	
A,	Examin		4a. Facility Name (If not institution, give	street and number)				th	4c. County of Dear		
			Mallard Bay C			Cambi			Dorche		
	Funeral Director		213-24-4784	7. Age (#	yrs. last birthday) 4 Yrs.	Months Days				hplace (State or Foreign buntry) Insylvania	
put	3		Usual Residence of Decedent 10a, State 10b, County	10	c. City, Town or Lo	cation				10d. Inside City Limits	
Aaryla	123a or 28a-f show stat be notified at	ŏ	MD Dorche		,.		nbridge			1 XYes 2 □ No	
7 =	28a-	Funeral Director	10e. Street and Number	-		10f. Zip Code		10	Og. Citizen of What Co	puntry?	
) F	Sa or	0	520 Glenburn Av	e.			21613		USA		
Jeath	ms 2	era	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Decedent of		Specify Yes or No- rto Rican, etc.)	14. Race - Ame		
fter	r ta	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕱 No				rto Hican, etc.)	Black, Whit		
03 ours a	Evan	þ	3 ☐ Widowed 4 💢 Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠ No	Specify:		Specify: wh	ite	
d 21215-0036 V CL	tal Hygiene. d other than "natural", or Itams event. the Medical Examination	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occu	during most of we		16b. Kind of Business	Industry	
Z igh	han a	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir			own home		
7 g	Hygier ther th										
Maryland d 2 should be file		Be	Clader Adla								
	if Health and Mental I Item 27 is marked o other traumatic eve	2	19a. Informant's Name/Relationship (T		19b Mailir	na Address (Stree			City or Town, State, 2	Zip Code)	
Ma d2s	atth and 27 is my r trauma		Shelly Haskett			-		rbutus, M		-,	
0 =	Heat tem 2 ther		20a. Method of Disposition		20b. Place of Dispo	sition (Name of			20c. Location - City or	Town, State	
	ant of t: # 1 y or o		1 ⊠Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State	-	natory`or other pl		7/29/05	Cambridge,	MD	
Baltimore,	Department of h Important: if Ite any injury or of once.	1	21. Signature 1 Funeral Service Licen:			2. Name and Addi			neral Home		
n g	Deg in a	Ų.	> the wolon	~	7	00 Locus		ambridge,			
	ysician		23a. Part / Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	death. Do not ent				st,	Approximate Interval Between Onset and Death	
	Medical caminer			Due to (or as a co	onsequence of):						
ted	nsit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury)								
8760, ate be execu	hysician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
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Hecords, P.O. Box 68760, The law requires that the death certificate be executed	attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	as decedent pregnant 23c. If yes, outcome or pregnancy 1 \(\to\) Live birth 2 \(\to\) Felal death 3 \(\to\) Ectopic pregnancy \(\to\) No \(\to\) A \(\to\) Pregnant at time of death 5 \(\to\) Other \((specify)\)							
at the	by the a	hys	9 Unknown	9 Unknown							
ecords, Flaw requires that	been signed t should be det	by	Part II. Other significant conditions co	ontributing to death but n	ot resulting in the u	nderlying cause g	ven in Part I.	23e. Did toba	accouse contribute to s 2 DNo 3 □ Pr	othe cause of death? obably 4 Dunknown	
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2 2 E	s b	Š						24a. Was an		topsy findings available	
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	s certificate has director, page 2	o Be	examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatier	nt 3 DOA		autopsy perform 1 Yes 2	prior to death? No 1 Yes	200 No	
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	•	-	For State	State of Maryla		artment of r ertificate of			2005	26491
			Registrar 1. Decedent's Name (First, Middle, La	st)		ranoato or		2. Date of Death		3. Time of Death
	Physicia /Medic		David Jonath	an Moreland	d			Month 8	Day Year	9:20A.M.
	Examin		4a. Facility Name (If not institution, giv	a street and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	
			5. Social Security Number 6. S	24 NOSPITC	yrs. last birthday	Umb If Under 1 Year	eriand If Under 24 Hrs.	B. Date of Birth	AlleGA	hplace (State or Foreign
	Funeral Director			86	88 Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day,) eb 2,1	917 West	untry) Virginia
Ħ	D		Usual Residence of Decedent	100	. City, Town or L	analian .				10d. Inside City Limits
	show	5	10a. State 10b. County Maryland Alle	gany	LaVal					1 X Yes 2 □ No
	28e-f	Director	10e. Street and Number	947		10f. Zip Code		10	g. Citizen of What Co	ountry?
	be filed within 72 hours after death with the Maryland a lytydene. A lother than "natural", or itams 23a or 28e-f show other than "natural", or itams 23a or 28e-f show event, its Medical Evaniter must be notified at	<u>a</u>	723 LaVale T	errace		215			USA	
	ams;	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	in U.S. 13	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
0	s afte	by FL	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No V If Yes, Give Year or Dates:	II WW	1 ☐ Yes 2 🛣 No	Specify:		Specify: W	nite
3	2 hour		15. Decedent's E	ducation	16a. Dec	edent's Usual Occup	pation	11	6b. Kind of Business	Industry
ה ה	thin 73	Completed	(Specify only highest gri	College (1-4or 5+)			during most of working d)			
V	led wil lygien har th		12	1	Sal	es Repr	esentativ		Construct	cion
2		Be	17. Father's Name (First, Middle, Last Furman H. Mon				Anna Spa	_		
Š	should nd Men marke	ဥ	19a. Informant's Name/Relationship		19b. Mai	ling Address (Street	and Number or Rural		City or Town, State,	Zip Code)
N	s 1 and 2 should t Health and Mer item 27 Is marke other traumatic		Mardal D. More		723	LaVale	Terrace			
e e	ges 1 a t of He If item or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	Ob. Place of Disp cemetery, cr	osition (Name of ematory or other pla	Aug 11	2005	Oc. Location - City or	
baltimor	permit. Pages Department of Importent: If it any Injury or o		*4 □ Donation 5 □ Other (Speci	fy) I	Hillcre	est Mem.	Park		Cumberla	nd, MD
מש	permit Depar Impor Impor any In		21 Signature of Funeral Service Lice			lafer Fu	ess of Facility neral Se	rvice,	PA	
			23a. Part1. Enter the disease of con shock, or heart failure. List only	iplications that caused the	ath. Do not e	1302 Nat nter the mode of dyi	.ional Hw ng, such as cardiac or	y LaVa respiratory arres	ale, MD st,	21502 Approximate Interval Between
	Physician		Immediate Cause (Final	one cause on each line.	-					Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cor	nsequence of):					- 120
	Examiner		Sequentially list conditions,	b. STAPHY! Due to (or as a cor	LDCOCC	US AU	REUS BA	4CTER	14	20495
1	ed sit	lnei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence or):	DU	1 11	VE FOT	2011	2 DAY1
4	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):	HCT IX	AU IN	1-661	1010	2 071)
90	ysiciar ie buri	calE	(d						
200	The law requires that the death certificate be existe has been signed by the attending physician page 2 should be detached for use as the burian	Med	IF FEMALE:		-					
gox	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of properties 1 Live birth 2 4 Pregnant at time	Fetal death 3	☐ Ectopic pregnand	Ç y		23d. Date of de Month	livery Day Year
	at the de by the a tached f	yslc	1 Yes 2 No	9 Unknown	or death 3	United (Specify)				
1	s that ned by e deta	Completed by Physician/Med	Part II. Other significant conditions	contributing to death but no	t resulting in the	underlying cause gr	ven in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
ras	w requires that been signed b should be deta	ed b	+SPIRATION	PNEUM	ONIA	RIGHT	LOWER	1 Te:	s 2 No 3 P	robably 4 Unknown
မင္ပင္	lawre as be	plet	LOBS					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Vital Records,		Соп							No 1 ☐ Yes	s 2□ No
VII	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpati	ent 3 DOA Ot	26. Place of Death		nce 6 Other (Spe	acifu)
ō	this ald	7: To	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time	of 28c. Inju			w injury occurred	ocny)
0	ath. r: Afte	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigate	on	ar) Injury		Yes 2□No			
Division of	iracto	Certification:	3 ☐ Suicide 6 ☐ Could not determined		At home, farm, pecify)	street, factory, office	, 2	8f. Location (Str. City or Town,	eet and Number or F , State)	ural Route Number,
	pital c		29a. Certifier 1 Certifying P	hysicien: To the best of my	v knowledge de	ath occurred at the t	ime, date and place, a	nd due to the ca	use(s) and manner a	s stated.
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Exe	miner: On the basis of exa	mination and/or	investigation, in my	opinion, death occurre	d at the time, da	ite and place, and du	e to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier	_ 0 1		29c. Licen	se number	29	d. Date signed (Mon	th, Day, Year)
			1 1 Cobustic	mo / 1/	anera	Y D-	14865	A	NG. 7-	,2005
1	7.41		30. Name and address of person who	completed cause of death	(Item 23a) (Typ	e, Print)	. / 0	. 0.	-hadla - 1	mA DIEAT
	- 0-		DR . KODUSTIAN 31. Date filed (Month, Day, Year)	O BHRRERQ 32. Registrar's :	Siggature	INVINORIO	LL HVENU	e, con	DERIUMA	III) and
	Sta Regist		AUG 1 2 20	05 Jennes.	13 199	Majorie,				m() 21505

			_ FOI	aryland / Depa			ental Hyg	giene,	20100
			1 - Stata Ragistrar	Ce	rtificate of l			Reg. No.	26492
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Dea Month	Day Year	
	/Medic	al		McCraw	4h Chi Taua	L costine of Dooth	July	19 2005 4c. County of De	5:23 p M
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death	ı_	Calve	
	Funeral		Calvert Memorial Hospital 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year		9 Date of Birth	0.8	irthplace (State or Foreign Country)
	Director		577-88-4081 ^{™ 2□ F}	49 Yrs.	Months Days	Hours Min.	Month, Day		Vash., D.C.
	pu .		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	faryla stron	ō	MD Calvert	l con only, round or Ed	Dunkir	k			1 □ Yes 2X No
	the N	rect	10e. Street and Number		10f. Zip Code			10g. Citizen of What (Country?
	3a or	0	2236 Harley Drive		20754			USA	
	death	Funeral Director	11. Marital Status 12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi	ispanic Origin? (Specin, Mexican, Puerto F	cify Yes or No-	14. Race - An Black, Wh	
0	or Ite	y Fu	1 Never Married 2 Married 1 Yes 2 No. If Yes. Give	10	1 ☐ Yes 2X No	Specify:	. ,	Specify:	
5000	filed within 72 hours after death with the Maryland Hygiene. Hygiene Inetural; or Items 23a or 28e-f show sht, the Medical Exam her must be redified at	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a Dece	edent's Usual Occupa	ation	1	16b. Kind of Busines	hite
<u>.</u>	in 72 n "nei redic	Completed	(Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired	during most of working	g	TOD. KING OF CUSINES	amousty
7 7	d with giene. rr thei	luo:	Elementary/Secondary (0-12) College (1-4or 5		ountant			tax prepa	ration
and	al Hyg	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden Sumame)	
<u> </u>	ould b Ment Ment arkec	To	John Robert McCraw			Helen	Louis		
Mar	iges 1 and 2 should be filed within 72 hours after death with the Marylan in of Health and Mental Hygiene. To Health and Mental Hygiene. To Health and Mental Hygiene. To other traumatic event, the Medical Examinat must be rollined at		19a. Informant's Name/Relationship (Type, Print)				_	r, City or Town, State,	Zip Code)
e,	1 and Health em 27 ther t		Helen L. McCraw, mother 20a. Method of Disposition	20b. Place of Dispo	Harley Dosition (Name of	Da	rk, MD	20754 20c. Location - City of	or Town, State
Бапптог	permit. Pages 1 and 2 Department of Health s Importent: If Item 27 is eny injury or other tra once.		1 🔀 Burial 2 □ Cremation 3 🔀 Removal from State '4 □ Donation 5 □ Other (Specify)	cemetery, cre	matory or other plac		2005	Roanoke,	
	nit. P artme orten injuri		21. Signature of Funeral Service Licensee		Cemetery 2. Name and Addres		-2003	roanore,	VA
ñ	permii Depar Impor eny ir once.		Wollow RG 10-	R	ausch Fun	eral Home	, P.A.,	Owings,	MD 20736
П	£.		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not en	nter the mode of dyin	g, such as cardiac or	respiratory ari	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	positive	e Sept	ricemia			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as	a consequence of):	6	+ 1=			
		16	Sequentially list conditions	a consequence of):	nsed	State			
	uted J ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Ciarho	Sis				
5	exec an an			a consequence of):					
0/90	death certificate be executed e attending physician and id for use as the burial-transit	dical	d						
Ď X	ertific ding p	/Mec	IF FEMALE: 23c. If yes, outcome	of pregnancy				001.01.11	
DOX	ie law requires that the death certifii has been signed by the attending i ge 2 should be detached for use as	Physiclan/Me	in the past 12 months?	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of d Month	elivery Day Year
	the de y the tched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown						
	s that the ned by th e detache	by PI	Part II. Other significant conditions contributing to death be	at not resulting in the u	underlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
coras	requires sen sign hould be	ed b	Henouhage				1 🗆 Y	es 2⊠No 3□I	Probably 4 Unknown
000	law re as bee 2 sho	Completed	Coagelo pattry				24a. Was a	an 24b. Were	autopsy findings available completion of cause of
	Th ate pag	Com	0 0				perfor	rmed death? 2 No 1 □ Ye	
VIII	Physicien: The this certificate al director, pag	Be (25. Was case referred to medical examiner?		Oth	26. Place of Death	(Check only or	ne)	
0	Physicien: this certific ral director,	-T	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatie 27. Manger of Death 28a. Date of Injur			4 Nursing Hon		lence 6 Other (Sp	pecify)
0	ding h. After funer	tlon	1 Natural 5 Pending (Month, Day 2 Accident investigation	Year) Injury	Worl	k? Yes 2 □ No	00. 00001100 11	ow injury occurred	
DIVISION	Atten r deal sctor: by the	ifica	3 Suicide 6 Could not be 28e. Place of Inju	ury - At home, farm, st	treet, factory, office	2		Street and Number or I	Rural Route Number,
5	s afte	Certification:	4 Homicide determined building, etc	;. (Specify)			City or Tow	mi, State)	
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edical	29a. Certifier (Check only) Certifying Physician: To the best of the basis of the	examination and/or in	th occurred at the tim	ne, date and place, a pinion, death occurre	nd due to the o	cause(s) and manner a	as stated. ue to the cause(s)
	thin 2.	Med	one) and manner sta	ited.	29c. License	e number		29d. Date signed (Mor	nth, Day, Year)
	F ≯ F 8		harry	MD	Do.	59409		07.20.	
	5		30. Name and address of person who completed cause of de	eath (Item 23a) (Type,	Driet	^			A A4.
	¥		155a YUSU- 110 Hos	11		rite 303	· Kan	nce trude	rich MD
	Sta Registr		31. Date filed (Month, Day, Year) V JUL 2 9 2005	S Signature	Sporte				

			For State Registrer	State of I	Marylan		artment of H		and Mental H	ygiene	05	261.02
			Hegistrer Decedent's Name (First, Middle, L.)	.ast)			inoato or E		2. Date of I	Death	00	3. Time of Death
	Physici /Medic		Walter Lance N	Miles					Month	25, 2005	Year	1600 M
	Examin		4a. Facility Name (If not institution, g	1 1	er)		4b. City, Town, or		1	4c. Count		
			0	925 A	ospit	al	If Under 1 Year	If Under	/	Prince	e L	erges
	Funeral Director		5. Social Security Number 219–35–0521	Sex 7. 1 2 M 2 □ F	Age (In yrs.)		Months Days	Hours	Min. May 2:	Birth Day, Year)	9. Birtho Cour Wa:	place (Plate or Foreign htry) Sh., DC
			Usual Residence of Decedent			<u> </u>			nay 2.	, 1705		
	uylan show	h	10a. State 10b. County		10c. City	y, Town or Lo	ocation				1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f s	Scto	Maryland Prince	George's			Bladensb	urg		10- 011	14/1	Λ
	with ti	Funeral Director	10e. Street and Number	C+ #1	r 2		10f. Zip Code	2071	10	10g. Citizen of		States
	leath ns 23	erai	5202 Newto	12. Was Decede	ent Ever in U.	S. 13.	Was Decedent of Hi		igin? (Specify Yes or I n, Puerto Rican, etc.)		ce - Americ	can Indian,
9	or Iter	Ē	1 ☐XNever Married 2 ☐ Married	Armed Force 1 Yes 2 If Yes, Give			lf Yes, specify Cuba 1 ☐ Yes 2 █ X No	n, Mexicar Specify:		Bla Specii	ıck, White,	etc. 1ack
21215-0036	ural', c	d by	3 Widowed 4 Divorced	Year or Date	s:							
15-("natu	Completed	15. Decedent's (Specify only highest of			(Give	dent's Usual Occupa kind of work done of DO NOT use retired.	during mos	st of working	16b. Kind of B	lusiness/In	dustry
12	within than than	dwo	Elementary/Secondary (0-12)	College (1-4	or 5+)		Auto Re	_	nan]	Priva	te
bc	e filed Il Hyg other	BeC	17. Father's Name (First, Middle, La	st)				18. Mothe	er's Name (First, Midd		тө)	
ylar	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examinational be neithed at	ToE	Jimmie Mu	rphy					Do1:	ly Miles		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Middel Examination at the nullitied at once.		19a. Informant's Name/Relationship Dolly Miles - I						er or Rural Route Num T4, Blade			0710
ore,	es 1 a of Hec litem		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□ Pamoval from Str		emetery, cre	sition (Name of matory or other place		Date	20c. Location	- City or To	own, State
im	Pag ment lant: I		`4 ☐Donation 5 ☐ Other (Spec	cify)	Ft		oln Cemet			100		d, MD
Baltimore,	permit Depart Import any In		21. Signature of Funeral Service Lic	Surgar	X.II	22			y Stewart g Rd., N.E			
	*		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau ly one cause on eac	sed the deatl h line.	h. Do not en	ter the mode of dying	g, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
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	*	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a conseq	uence of):					-	
	outed Id ansit	Examiner	that initiated events	C.								
oʻ	e exection and an arrial-tr	Exa	resulting in death) Last	Due to (or	as a conseq	uence of):						
8760,	icate be executed physician and s the burial-transit	dical		d								
9 ×	leath certific attending pl	Physician/Med	IF FEMALE:	23c. If yes, outco	me of pregna	incv				23d Da	ate of delive	arv.
Вох	atten d for u	cian	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1☐Live birth	n 2 ☐ Feta It at time of d	I death 3	Ectopic pregnancy Other (specify)			,	onth	Day Year
0	that the de ned by the a detached f	hysi	9 Unknown	9□ Unknow	n							
s, P	8 50	by	Part II. Other significant conditions	s contributing to deat	h but not res	ulting in the u	nderlying cause give	en in Part I		d tobacco use con ☐ Yes 2 ☐ No	itribute to th	he cause of death?
Records,	w require been sij	Completed									_	
3ec	The law ate has t page 2 s	mpf							24a. Wi	as an 24b. topsy rformed?	prior to co	ppsy findings available impletion of cause of
a	n: Th	e Co	25. Was case referred to medical					26 Place	1 ☐ Yes e of Death (Check ont		1 🗆 Yes	2 □ No
Vital	Physician: this certific ral director,	To B	examiner?	Hospital:	atient 2	ER/Outpatie	nt 3 DOA Othe	0.00	ursing Home 5 Re		her <i>(Specil</i>	·v)
J of			27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of (Month.	Injury Day Year)	28b. Time o	f 28c. Injury Work		28d. Describ	e how injury occur		ing
sior	Attending r death. ector: After y the fune	catic	2 Accident investigat	ion July 19	2005	19%	Z M 10'	Yes 2		., .	hom	
Division	or Att	Certification:	3 XSuicide 6 ☐ Could not 4 ☐ Homicide determine	a 286. Place of	Injury - At ho , etc. <i>(Specif</i>	y) L	reet, factory, office		City or 1	(Street and Num. Town, State)	202	Newton,
	pitel ours a neral C		29a Certifier 1 ☐ Certifying	Physicien: To the be	ast of my kno		owe	ne date an	nd place, and due to the	1		W I
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical			s of examina				ath occurred at the tim			
	To th withir To th comp	Me	29b. Signature and title of certifier	4.0			29c. License	e number		29d. Date signe	ed (Month,	Day, Year)
•			1 Dood	Also	5 9	00	140	055	5827	July	. 26,	2005
) 1	3)	Į į	30. Name and address of person wh	o completed cause	of death (Item	л 23а) (Туре,	Print)		Chever	(1	4 \ 4
		ate	31. Date filed (Month, Day, Year)	31 er 30	istrar's Signa	15/16	y Uran	ve (mover	MA	7 (00	~ a
	Sta Regist		JUL 2 9 201	_	w JK	Apo	W				•	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Robert Earl 11:50 P M 26, July 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital 01ney Montgomery If Linder 24 Hrs 8. Date of Birth (Month, Day, Year) Oct. 21, 19 Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 1 → M 2 □ F **1**927 77 282-24-1125 Oct. Director Michigan Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-1 show important: If Item 27 is marked other than "natural", or other traumatic event, the Medical Examinar must be motified at once. 1 Yes 2X No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 3485 South Leisure World Blvd. 20906 IISA death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Ital 1 AYes 2 No If Yes, Give Korean 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Conflict SpecifyWhite þ 3 XWidowed 4 □ Divorced ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) 4 Executive Steamship Industry 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer Earl Metz Iris Slingo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 754 Arch Stone Drive, San Antonio, TX 78258 Christine M. Murray/ Daughter 20b. Place of Disposition (Name of cometery, crematory or other place)
Maryland Veteran's Date 20a, Method of Disposition 20c. Location - City or Town, State August 2, 1 x Burial 2 □ Cremation 3 □ Removal from State 9 Ž005 Crownsville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Eacility Francis J, Collins Funeral Home Inc 21. Signature of Funeral Service Licensee Kein 500 University Blvd, W, Silver Spring, MD 20901 23a. Pond. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 12 HOVRS RESPIRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the 9 Unknown à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ CONGESTIVE HEART FAILURG 1 Yes 2 No 3 Probably 4 Unknown Completed LUMBAR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CHRONIC has autopsy perform 1 ☐ Yes 2 ☐ No certificate 2 **X**No Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 0 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending Natural 2 Accident 1 ☐ Yes 2 ☐ No hours after death. investigation within 24 hours after deatl To the Funeral Diractor; 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JULY 27, 2005 In Him 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONEY, MARYLAND 20832 RTE 108 CM NONNAH 29 posts 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien $\mathbf{e} \cup \cup \mathbb{D}$ For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 27 2005 July 2250 Clarence George Murray 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Worcester Atlantic General Hospital Berlin 8. Date of Birth (Month, Day, Year) Aug. 25,1921 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 11XM 2□ F Months Days Hours Min 165-14-3369 83 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Delaware Aston Township PA10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19014 USA 32 Penns Court 12. Was Decedent Ever in U.S.
Amed Forces?
1 X Yes 2 □ No 1944If Yes, Give 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: 1946 White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Maritime Elementary/Secondary (0-12) College (1-4or 5+) Marine Engineer Transportation 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edwin T. Murray Lillie B. Pepper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine J. Murray/Wife 32 Penns Court, Aston, PA 19014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 X Removal from State * 4 ☐ Donation ☐ Other (Specify) Philadelphia Memorial 8/3/2005 Frazer, PA 19355 21. Signature of Funeral Service Licensee 22. Name and Address of Facility White-Luttrell Funeral Homes, 3551 Concord Road ecucu Aston, Pennsylvania 19014 28a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pheumonia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2™No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 24a. Was an autopsy performed 1 🗌 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes npatient 2 ER/Outpatient 3□ DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 atural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation

Physician /Medical Examiner

Important: If item 27 Is, any injury or other

Physician

/Medical

Examiner

Funeral

Director

28a-f show

other traumatic event, the Medical Examiner must be notified at

"natural"

2 should be a

imore, Mary

Balti permit.

Box 68760.

Record

Vital Physician:

Division Hospital or Attending by

burial-transit attending physician Physician/Medical the à ģ Completed certificate has page. funeral director, Be 24 hours after death. e Funeral Director: After this Certification: filled in by

3 Suicide

29a. Certifier

cal

State

Registrar

4 Homicide

(Check only one)

29b. Signature and tyle of certifier

Location (Street and Number or Rural Route Number, City or Town, State)

1 🖵 Ceptifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Berlin

29c. License number 536/2 29d. Date signed (Month, Day, Year)

Son who completed cause of death (Item 23a) (Type, Print)
Barr 973 Health v 30. Name and address of pe thdrea

6 Could not be determined

2 Medical Examiner:

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) 32. Registras s Signature

and manner stated

SAREL

2005

within 2 To the

			1 - For State Registrar		State of	Marylan	-	artment rtificate				lental H	ygiene Reg. R e		5 4	26496
	Physic	ian	1. Decedent's Name Harry	(First, Middle,	E.	N	ealis					2. Date of I	Death Da	y 🔾	Year	3. Time of Death
7	/Medi Examir		4a. Facility Name (If r	not institution,			calls			Location of	of Death			. County o		a.w ₁
			56 Maple			A //	to an to trade of a st	Cum If Under		and If Under	24 Ure	0.00	1 -	llega		
	Funeral Director		5. Social Security Nur 214-07-19 Usual Residence of D	998	. Sex 7. 1 ☑ M 2 □ F	Age (In yrs. I	Yrs.	Months	Days	Hours	Min.	8. Date of E Month Jul 7,	1910)	9. Birthpi Coup	lace (State or Foreign
	Maryland I-f show, Ifled III	tor		10b. County Alleg	any	10c. City	y, Town or Lo Cumb	cation perlan	d						10	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 23a or 284	Funeral Director	10e. Street and Numb					10f. Zip		21502	2		10g. Cit	izen of WI		try?
9036	be filed within 72 hours after death with the Maryland ital Hyglene. Idea Hyglene and an actual; or Items 23a or 28e-f show, event, the Medical Evandar must be inclified at		11. Marital Status 1 □ Never Married 3 □ Widowed		12. Was Decedd Armed Forc 1 Yes 2 If Yes, Give Year or Date	es? ☑ No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or I Rican, etc.)	No-	14. Race Black Specify:	, White, e	etc.
21215-0036	C * 33	Completed by			Education grade completed) College (1-4	or 5+)	16a. Deced (Give life. I Spinni	kind of wor DO NOT us	k done a e retired,	ation Juring most)	t of worki	ng	Tex	ind of Bus tile	iness/Ind	lustry
Maryland 2	nd 2 should alth and Mer 27 is marke in traumatic	Be	17. Father's Name (F. Joseph		st)							(First, Midd t Hain)	
			19a Informant's Nam Marilyn N	ne/Relationship ealis	^(Турө, Print) dau	ighter	19b. Mailir 56 N	a Address Saple	(Street a Stree	and Numbe E t	er or Rura	Cum	ber, City o berla	nd s	tate, Zip MD	21502
Baltimore,			20a. Method of Dispo 1 Burial 2 4 Donation 5	Cremation 3	□Removal from Sta	! C	lace of Dispo emetery, cren Ashby (natory or ot	her olacı	9)		ate 3/12/200	_	rt Ash	•	wn, State
Balti	permit. Departn Importa any inju		21. Signature of Fune	Prail Service Lie	cense	M	22					me, PA Cumbe		MD 2	1502	
	Physician		23a. Part1. Enter the shock, or heart Immediate Cause (Fi disease or condition	failure. List or	ly one cause on eac	sed the death h line. Ha 870		Prost					arrest,	-		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		a	as a consequ	uence of):	~e								-
H.	uted d ansit	Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in) that initiated events	itions, nediate ring jury	Due to (or	as a consequence die t	ience of):	ona	щ	ar	res	1-				
8760,	icate be axecuted physician and s the burial-transit	ical Exa	resulting in death) La	st	Due to (or	as a consequ	uence of);		ر							
.O. Box 68	law requires that the death certificate be axecuted as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 1 9 Unknown	onths?		n 2 ☐ Fetal t at time of de	death 3	Ectopic pre						23d. Date Monti		y Day Year
rds, P.	quires that in signed by uld be deta	by	Part II. Other significa	ant condition	contributing to deat	h but not resu	ulting in the ur	nderlying ca	use give	n in Part I.					ute to the	e cause of death?
æ	Tha ate h	Completed											opsy formed?	pri	or to com ath?	sy findings available upletion of cause of
Vital	Physician: this certific ral director,	o Be	25. Was case referred examiner?		Hospital: 1 ☐ Inp	nainna O' T	FB/0-1	200	Othe	F:		(Check only		2 (70)		
of	ding h. After fune	-	27. Manner of Death	5 Pending	28a. Date of I (Month,		28b. Time of Injury		lc. Injury Work			8d. Describe	sid e nce (how injur			
=	al or Attendi after death. I Director: A d in by the fu	Certification	3 Suicide 4 Homicide	6 Could not determine	ad 286. Place of	Injury - At ho etc. (Specify	me, farm, stre	eet, factory,	office		2		(Street and own, State		or Rural	Route Number,
	To the Hospital or Attentwithin 24 hours after deall To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 (Check only 2 one)	Certifying Medical Ex	Physician: To the be aminer: On the basi and manner	s of examinati	wledge, death ion and/or inv	occurred a estigation,	t the time	e, date and inion, deat	d place, a h occurre	and due to the	e cause(s) , date and	and manr place, an	er as sta d due to t	ited. the cause(s)
)	To th withir To th comp	Me	29b. Signature and tit	le of certifie					License		46	39		e signed (
	5		30. Name and addres	s of person wh		of death (Item	23a) (Type, I	Print)	4	An	. 1	umh	-1-		M / K	2502
	Sta	_	31. Date filed (Month,		A'	istrar's Signat	ure	gini	م جر	7)	,, 0	411112	rca	7	MD	200
	Registr	ar	AUG	1 2 200	1 Police	LF.	GOBALL.									

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i> a	artment of H			giene Reg. N2 0 0 5	26497	
	Physici	an	1. Decedent's Name (First, Middle, Last) Ted Steven					2. Date of Dea	ith	3. Time of Death 8:35 A. M	
	/Medic Examir		4a. Facility Name (If not institution, give st Calvert Memorial H	street and number)		4b. City, Town, o		ath	4c. County of Deat		
	Funeral Director		5. Social Security Number 430–98–1624 Usual Residence of Decedent	M 2015	(In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		9. Birth (, Year) Ala	nplace (State or Foreign untty) ISKA	
	within 72 hours after death with the Maryland sne. than "natural", or Items 23a or 28a-f show than Madical Examination and Item Madical	Funeral Director	10a. State 10b. County Maryland Calvert 10e. Street and Number		10c. City, Town or Lo				10g. Citizen of What Co	10d. Inside City Limits 1 Yes No	
	23a or	ai Dir	1750 Walnut Road			20676			United Stat	•	
9800	s within 72 hours after death with the Marylan Jene. r than "natural", or Items 23a or 28a-f show the Madical Examiliset must be notified at	þ	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	1060	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 💆 No		(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.	
d 21215-0036	be filed ital Hygi d other event.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+ 4	(Give	dent's Usual Occup kind of work done DO NOT use retire unication	during most of w d)		16b. Kind of Business/Communicati		
Maryland		To Be (17. Father's Name (First, Middle, Last) Chalmer Floyd Post				Doris				
	d 2 s than 7 is trau		19a. Informant's Name/Relationship (Ty. Della R. Post (Wif						r, City or Town, State, Z ic, Marylan		
Baltimore,	Pages 1 and nent of Heali ant: If Item 2 ary or other		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Disponsion Commetery, cremetery, cremetery	natory or other pla	· 1		20c. Location - City or Alexandria,		
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License						neral Home, ort Republi	P.A. c, MD 20676	
8760,	be attending physicien and for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of): consequence of): consequence of): consequence of):	dney	z Cino	ma O	est. La stases	Approximate Interval Between Onset and Death	
.O. Box 6	the the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	Ectopic pregnancy	/		23d. Date of deline Month	very Day Year	
<u>α</u>	sign d be	by	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to		
al Records,	The law ate has b page 2 s	Completed						24a. Was a autops perform	sy prior to c med? death?	topsy findings available ompletion of cause of	
ion of Vital	ding Phys n. After this funeral dir	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 to H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Dipoation 28a. Date of Injury (Month, Day	28b. Time of	28c. Injur Wor	er: 4 ☐ Nursing	-	ence 6 ⊡Other (Spec ow injury occurred	ify)	
Division	in the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur- building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (St City or Town	on (Street and Number or Rural Route Number, r Town, State)		
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the form of the filled in t	edicai	29a. Certifier 12 Sertifying Physical (Check only one) 12 Medical Exemination (Check only one)	ician: To the best of ner: On the basis of e and manner state	examination and/or inv	n occurred at the tirvestigation, in my o	me, date and pla pinion, death oc	ce, and due to the courred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)	
)	To the within To the comple	Me	29b. Signature and title of certifier	r. MD Azlandy	Physici	29c. Licens	e number	2	9d. Date signed (Month	and Committee	
0	10+1		30. Name and address of person who co		V		303. Pi	rince Fr	ederick,	MD 20678	
	Sta Registr	te	31. Date filed (Month, Day, Year)	32. Registr	s Signature	Sperker			- CACLION,	20010	

			- FOr	partment of Health and I e <i>rtificate of Death</i>		ene .2005 26498
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	
	Physici /Media		Melvin P. Parker		July 26	M
	Examir		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			416 Collins Road	Edgewater	100 : (8:0	Anne Arundel
ı.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min.	(Month, Day,	
	Director		216-24-2630 77		March 2	4 1928 Maryland
	land		10a. State 10b. County 10c. City, Town o	Location		10d. Inside City Limits
	Man,	to	Maryland Anne Arundel Edgewa	tor		11⊠Yes 2 □ No
	h the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	death with the Maryland me 23e or 28a-f show rmust be rediffed at	alD	416 Collins Road	21037		USA
		Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	hours after death with the Marylan jural', or Iteme 23e or 28e-f show il Esaninar must be rollfied at	by Fu	1 □ Never Married 2/2 Married 1 □ Yes 2 □ No If Yes, Give 1950-51	1 ☐ Yes 2₺ No Specify:		Specify: Black
8	"natural",	pa pa		cedent's Usual Occupation	11	6b. Kind of Business/Industry
15	- 28	piet	(Specify only highest grade completed) (G	ve kind of work done during most of wor b. DO NOT use retired)	rking	Andrews Air Force
212	o filed within I Hygiene. other then "	Completed	Elementary/Secondary (0-12)	ief of Supplies		Base
ğ	be filed withing tall Hygiene. d other then event, tre M	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nar	ne (First, Middle, M.	
lar	Alental	To E	Wilbert Parker	Lore	na Dorse	ey
Maryland 21215-0036	es 1 and 2 should be fi of Health and Mental H I Item 27 is marked ot r other treumatic ever		19a. Informant's Name/Relationship (Type, Print) 19b. M	tiling Address (Street and Number or Ru	ral Route Number,	City or Town, State, Zip Code)
	and and n 27			Collins Rd. Ed	gewater	, Md. 21037
ore	of H of H if Iter		1 Burial 2 Cremation 3 Removal from State	position (Name of rematory or other place)		Oc. Location - City or Town, State
Ë	Pag ment ent: jury c		*4 □Donation 5 □Other (Specify) MOSeS		0/05	Drury, Md.
Baltimore,	permit. Pages Depertment of the Importent: If Ite any injury or of once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Wm Reese & Son	s MOrtu:	ary P A
	707 e o		Larry B, Teese MOOT 83	Wm. Reese & Son 821 West St. An	napolis	Md . 21401 Approximate
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Cancer		Interval Between Onset and Death 4 mon 41
90,	cate be executed by sicien and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
	The law requires that the death certificate be e- te has been signed by the ettending physicien bage 2 should be detached for use as the burit	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3□Ectopic pregnancy 5□ Other (specify)		23d. Date of delivery Month Day Year
rds, P	quires that n signed l	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Records,	sicien: The law require certificate has been si irector, page 2 should b	Completed			24a. Was an autopsy performs	prior to completion of cause of
ital	ien: rtifica stor, p	Be C	25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one))
	> 5 D	To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	ient 3 DOA Other: 4 Nursing H	ome 5 Residen	ce 6 Other (Specify)
0	E is		27. Manner of Death 1	y Work?	28d. Describe how	v injury occurred
Sio	Attending ir death. ector: After by the funer	cati	2 Accident Investigation	M 1 Tyes 2 No	00(1) 11 (0)	
-	tal or Attendir rs after death. el Director: Af ed in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	City or Town,	set and Number or Rural Route Number, State)
	To the Hospital or within 24 hours after To the Funerel Dire completely filled in b	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medicel Examiner: On the basis of examination and/o and manner stated.			
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
•			MATTA A- Colon	6 HOOS55	t2 Ji	142/2005
			30 Name and address of person who completed cause of death (Item 23a) (Ty	e, Print)	1- R	15t, 10 2 1:5 2145
			31, Date filed (Month, Day, Year) 32, Restrar's Signature	888 Besta	114 14	a mapily with
	Sta Registi	_	31. Date filed (Month, Day, Year) 32. Restrar's Signature	Smith		

1	400		1 - State Unpend Item Registrar AMFND III	State of 23a&27 pc	Marylar e r me FH G 8	nd / Depa G846-8 46 -872	artment =16-05 576919	of Hea	alth and eath	Me	ntal Hyg	giene Reg. No.)	0.05	261	. 0 0		
	Physici /Medic		1. Decedent's Name <i>(First, Middle, L</i> Martin Paulin Pa	.ast)						2.	Date of Dea Month USUST	Day 04	Year 2005	8:24	Death P		
	Examir		4a. Facility Name (If not institution, g Interstate 495 Fast			er 28			cation of De	ath				h	-		
O X o	Funeral Director		5. Social Security N 2995 6. 016-40-2 295	Sex 7. 1⊠ M 2□ F	Age (In yrs.	last birthday) Yrs.	If Under 1	Year If	Under 24 H Hours Mi	rs. 8. in.	Date of Birt. (Month, Day	h	9. Birt	hplace (State	or Foreign		
_	ehow	7	Usual Residence of Decedent 10a. State 10b. County		1	ty, Town or Lo								10d. Inside (City Limits		
	e Man	ctor	Maryland Montgo	nery	Gai	thersb	urg							1 ☐ Ye	s 2 🔀 No		
	h with th	al Dire		ad										untry?			
980	urs after deat ei', or itame ' Exeminer mu		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ②XDivorced	Armed Force 1 Yes 2 If Yes, Give	es? No		If Yes, specif	y Cuban, N	Mexican, Pu	(Specifi erto Ric	y Yes or No- an, etc.)		Black, White	e, etc.			
5-0	72 ho	eted	15. Decedent's (Specify only highest g	Education rade completed)		(Give	kind of work	done durin	n ng most of w	vorking		16b. Kind	of Business/	Industry			
2121	d within glane. or than	ошо	Elementary/Secondary (0-12)	College (1-4 4	or 5+)				nt			Const	ructi	on Fir	m		
land	uld be file fental Hy rked other tic event.	Be	17. Father's Name (First, Middle, Last Leopold Pare	st)							_		2005 8:24 P unty of Death Ontgomery 9. Birthplace (State or Foreign Country) (1) Canada 10d. Inside City Limits 1 Yes 2 No of What Country? ada Race - American Indian, Black, White, etc. ecity: White of Business/Industry ruction Firm mame) own, State, Zip Code) (1, MD 20877 on - City or Town, State Indria, Virginia Home, ersburg, MD 20877 Approximate Interval Between Onset and Death Date of delivery Month Day Year Contribute to the cause of death? o 3 Probably 4 Unknown 4b. Were autopsy findings available prior to completion of cause of death? 10 Yes 2 No Cother (Specify) at Scene courred Country Coun				
Mary	Pages 1 and 2 shot nent of Health and A that: if item 27 is ma iny or other trauma			Former								-					
			20a. Method of Disposition 1 ☐ Burial 2 分Cremation 3	☐Removal from Sta	20b. F	Place of Dispo cemetery, crea Metropo	osition (Name matory or oth Dlitan	of er place)	Aug	Date	9,	20c. Locat	ion - City or	Town, State	nia		
Balti	Departm Importar eny inju		A		0689	22	2. Name and	Address o	f Facility	DeV	ol Fur	neral	Home,				
8760,	Physician and /Medical Examiner and physician and physicia	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Non Si Due to (or Due to (or c.	na11-C as a conseq as a conseq	uence of): uence of):	rcinom	a of	Lung					Onset and	Death		
O. Box 6	0 00 0	yslclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1☐Live birth 4☐Pregnan	n 2 ∐ Feta tattime of d	I death 3						23d		,	Year		
<u>α</u>	equires that en signed b ould be deta	ed by PI	Part II. Other significant conditions	contributing to deat	h but not res	ulting in the u	nderlying cau	ise given ir	Part I.						,		
al Reco										-	autop. perfor	med?	prior to death?	ompletion of	available cause of		
Zi.	Second S	Other (Spec	wat s	cene													
ion of	After fune	ation: T	1 Natural 5 Pending	28a. Date of I (Month,	njury	28b. Time of	280	: Injury at Work?						,, 40 0			
Divis	al or Atte s aftar de ii Directo od in by th	Sertific		d 286. Place of	Injury - At h	ome, farm, str	eet, factory, o	office		28f.	Location (S City or Tow	treet and N n, State)	umber or Ru	ral Route Nui	mber.		
	Hospit 124 hour Funera letely fille		(Check only ZIX) Medical Exa	animer: On the basi	s of examina	wledge, death	n occurred at vestigation, in	the time, on my opinion	date and pla on, death oc	ce, and curred	due to the o	ause(s) and late and pla	d manner as ice, and due	stated. to the cause((s)		
	To th within To th compl	Me	29b. Signature and title of certifier	(700	,	29c. 1	_icense nu	mber		2	29d. Date s	igned (Monti	, Day, Year)			
	12		39. Name and address of person who	completed cause	of agath (Iten	n 23a) (Type,	Print)										
			VATRICIA ACC	- Asing	KILLY	KW21	1 Penr	Str	eet, E	Balt	imore,	, Mary	land :	21201			
***				2005	istrar's Signa	F. Ap	and										

)	.000		1 - Stata amended #19b	State of Marylan perFH; FCHD				ealth and Death tr				26500
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Carol R.	PRO	CTOR				Mor	of Death oth V	Day Year	3. Time of Death
**	Examin Funeral Director		211-26 0603		last birthday) Yrs.	Ada	amstov er 1 Year	If Under 24 H	eath Irs. 8. Date in. (Mor	of Birth	Frederic ar) 9. Birth Cou	
	he Maryland 18a-f ahow	ector	Usual Residence of Decedent 10a. State 10b. County Fredevice 10e. Street and Number	/	y, Town or Lo	Dur				100	Citizen of What Cou	10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow minportant: if item 27 is marked other than "natural", or items 23a or 28a-f ahow principly or other traumatic avant. If a Medical Exact or must be notified at ances.	Funeral Director	2789 Adam	2. Was Decedent Ever in U. Armed Forces?	.S. 13.1	Was Dec	ip Code 21 edent of Hillery Cuba	710 spanic Origin? n, Mexican, Pu	(Specify Yes	or No-	14. Race - Amer Black, White	ican Indian,
5-0036	2 hours afte atural', or il cal Exarcin	by	3 Widowed 4 Divorced 15. Decedent's Educ		16a. Dece	dent's Us					Specify: BL	ndustry
2121	filed within 7 Hygiene. other than "n	e Completed	(Specify only highest grade Elementary/Secondary (0-12) 12 YCCLS 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life.	DO NOT	use retired	JCWSP	aper	PW		Harala Association
Maryland	2 should be and Mental is marked o	To Be	Robert Ign qti 19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailir	ng Addre	ss (Street a	Ina t	FUELY,	Nymber, Cit	ty or Town, State, Z	ip Code)
Baltimore, N	Pages 1 and lent of Health int: If Item 27 iry or other tr		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		lace of Dispo	sition (N	ame of	remar	Date Ca	stro 20c	Valley C . Location - City or 1	A 94546 Town, State
Baltin	permit. Page Department Important: If any injury or		21. Signature of Funeral Service License	Pollin	22 6.	Name :	and Addres	s of Facility OLUMS OUR	FUN!	ERAL	Home	21701
8760,	Physician /Medical Examiner prize polysician up prize	dical Examiner	23a. Part1. Enter the diseast or complic shock, or heart failur. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	7.00	arl				Carl	Approximate Interval Between Onset and Death
O. Box 68	he death certifi the attending thed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I déath 3	Ectopic Other (pregnancy specify)				23d. Date of delin	very Day Year
Records, P.	w requires that the been signed by should be detact	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying	cause give	en in Part I.	236	e. Did tobacc	^	the cause of death?
tal Reco	The law ate has b page 2 sl	e Completed	25. Was case referred to medical					00 81		. Was an autopsy performed Yes 2	prior to c death?	opsy findings available ompletion of cause of
ion of Vital	ding Phys h After this funeral dii	ToB	examiner?	ospital: 1	ER/Outpatier 28b. Time of Injury		28c. Injury Work	at	g Home 5[Residence	e 6 Other (Special of the first occurred)	ify) at scene
Division	or At	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y) 	D'COM			City	or Town, Si		4101304300000
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 X Medical Examin	ician: To the best of my kno ter: On the basis of examina and manner stated.	wiedge, deati tion and/or in	vestigatio	on, in my of	oinion, death o	ace, and due courred at the	time, date	and place, and due	to the cause(s)
	Mill To Con		29b. Signatule and title of certifier	mD	1 22a) /T =	(9c. License				Date signed (Month 1y 25, 20	
	Sta Registr	- 1/2/4	31. Date filed (Month, Day, Year)	mpleted cause of death (Iten 32. Registrar's Signa)	Print)	1 3					